

Committee
Findings and Recommendations

DCF Monitoring and
Evaluation

Approved December 20, 2007

Legislative Program Review
& Investigations Committee

DCF Monitoring and Evaluation

The Legislative Program Review and Investigations Committee authorized a study to assess comprehensively the internal and external efforts to monitor and evaluate the Department of Children and Families in April 2007. Past program review committee studies have examined DCF and how the agency carries out its child welfare, juvenile justice, behavioral health, and prevention services mandates. They identified ways to make various department programs more efficient and effective to better address the needs of at risk children and families. The current study seeks to improve outcomes agencywide by ensuring DCF makes policy decisions and manages programs for children and families based on results information.

A results-based monitoring and evaluation system is important for three main reasons:

- If effective, it provides the agency with feedback on actual outcomes and assesses progress toward desired goals.
- It allows managers, policymakers, and stakeholders to know where the agency is going, why it is successful or not, and how to make improvements.
- In the end, it helps the agency provide better services for children and families and make better use of taxpayer resources.

Therefore, the PRI study sought to answer the following main questions:

- How is progress tracked by DCF and others?
- Is the system for monitoring and evaluating DCF providing feedback on how well the agency is meeting its goals?
- What has DCF accomplished?
- Are the findings from monitoring and evaluation efforts used to make changes to agency policies, programs, and services that improve outcomes for children and families?
- What changes can be made to the DCF accountability system to help the agency better meet the needs of children and families?

Summary of Findings and Recommendations

Although the department is responsible for four mandates related to children and families, the focus of the DCF monitoring and evaluation system has been on child protective services. This is driven in large part by the *Juan F. Consent Decree* and federal child welfare requirements overseen by the Children's Bureau of the U.S. Department of Health and Human Services (DHHS).

Little attention has been given to monitoring and evaluating the agency as a whole, which limits assessment of DCF's achievement of its overall mission. A comprehensive strategic plan that would promote more agencywide thinking and direction does not exist. Action-based plans are a successful monitoring and evaluation tool at DCF, leading to improvements in services for children and families.

The focus of most DCF monitoring and evaluation has been on tracking how services are delivered rather than their end results. While quality service delivery is crucial, a key indicator of effectiveness is whether the service is having the hoped for impact on recipients. Outcomes are difficult to measure, but attention must be given to whether programs are making a difference, particularly when there have been large investments made to improve service delivery.

Overall, the committee found program goals were stated in a way that allowed them to be readily monitored and evaluated. A major exception was in the area of performance-based contracting. Multiple deficiencies were found regarding the monitoring and evaluating of contractors. Provider data requirements were vaguely worded in many contracts. In contracts where data requirements are enumerated clearly, providers are expected to use their own resources to configure data extracts to provide to DCF, often with no clear understanding of why DCF needed the information. Rarely do they receive analysis or other feedback from DCF. Therefore, contractor performance data may or may not be submitted; often, what is provided is of poor quality, incomplete, or duplicative.

Monitoring of contractors is inconsistent, often depending on the time of the program lead, a role that is part-time and sometimes vacant. Lacking feedback to hold providers accountable, the department many times renews contracts without serious consideration of service quality.

Quality improvement efforts are fragmented across the agency. The agency's antiquated, cumbersome automated system, called "LINK," contributes to the lack of coordinated outcome information across the agency. Despite more than a decade of attempting to successfully implement the system, the federal government monitoring this implementation does not document major gains.

The committee found several instances of effective external monitoring and evaluation efforts. These include the *Juan F.* consent decree exit plan process and other court monitoring processes. Oversight by the Office of the Child Advocate, particularly through its ombudsman efforts, also have led to improvements in services to children and families. On the other hand, in general, DCF advising bodies were found to have little impact. This is due, in part, to the lack of clarity regarding their roles and responsibilities.

Framework. To put the assessment of the DCF monitoring and evaluation system in context, the program review committee staff applied a framework for child welfare quality improvement developed by the National Child Welfare Resource Center for Organizational Improvement (NCWRC). This center is one of seven technical assistance and training organizations funded by the Children's Bureau of the U.S. DHHS that supports state agencies that serve children and families. The organizational improvement center helps states with

strategic planning, implementing quality improvement, evaluating outcomes, and facilitating stakeholder involvement.

The NCWRC framework for child welfare quality assurance includes five key elements all agencies should consider in creating new systems or “energizing” existing systems. (Core components of the framework are outlined in Appendix A.) It is based on examples from ongoing quality improvement efforts in a number of state child welfare agencies, federal requirements, research and management studies, and national quality assurance standards developed for other settings.

The framework’s five main elements are outlined in Table I-1. The committee findings and recommendations developed by applying the framework to the DCF monitoring and evaluation system are summarized in the table as well.

As the table indicates, committee recommendations are aimed at strengthening each of these elements within DCF. No matter how an agency is organized, better outcomes from programs and services are more likely if managers have an effective system for tracking, reviewing, using, and reporting on results. The recommendations included in this report are intended to make quality improvement efforts consistent throughout the department and sustainable over time. The goal is to achieve, as many in the department expressed during the study, a culture of results-based decision making that, most importantly, is focused on better outcomes for children and families.

Methodology

Committee staff employed two main research methods to study the DCF monitoring and evaluation system: key stakeholder interviews; and analysis of monitoring and evaluation reports and related documents produced by internal, external, investigative, and advisory sources.

Key stakeholder interviews. Committee staff conducted approximately 100 interviews with division and unit personnel within the DCF bureaus, as well as court monitor staff, Office of the Child Advocate staff, advising body chairs, federal agency officials, external evaluators, and representatives of providers, and advocacy groups. Efforts were made to visit or interview staff from a full range of agency offices and facilities; however, given the time and resource constraints of the study, not every area office or DCF facility could be visited.

Analysis of monitoring and evaluation reports. Committee staff reviewed 126 reports and materials pertaining to monitoring and evaluation of DCF. The study focused on reports and other materials documenting monitoring and evaluation efforts that occurred within the past three to five years (through September 2007). In order to assess the efforts, PRI staff evaluated each document using an internally developed standardized rating system. Ratings required agreement between two PRI staff who had independently reviewed the documents and then met to discuss their ratings. Committee staff acknowledges that, due in part to the fragmentation of the monitoring and evaluation system, there are likely other reports that could have been included in this analysis. Due to time constraints and lack of a centralized repository for such information, PRI staff attempted to analyze a representative sampling of information favoring what would be

considered major programs within the department. Section II provides more detail on the areas rated for each monitoring and evaluation effort.

Table I-1. Framework for An Effective Quality Improvement (QI) System		
Main Elements (NCWRC Framework)	Committee Findings about DCF	Committee Recommendations
Agency has adopted outcomes and standards	No single compilation of all goals within agency, across all mandate areas and programs Most current goals focus on how services are delivered (process) rather than outcomes for children and families	Strategic planning process with community/stakeholder involvement
Quality assurance and quality improvement are incorporated throughout the agency	Fragmented; pockets of strength (e.g., <i>Juan F. Exit Plan</i> compliance activities, area office QI process, residential facility licensing, evidence-based models for behavioral health in-home services) and major gaps (e.g., ineffective use of findings from internal and contracted program evaluations, special reviews, no compilation and comparison of results data from all sources) Weak procurement process and ineffective performance-based contracting	Dedicate staff resources to integrating, analyzing, and reporting on outcomes related to all the goals and mandate areas of the agency Maintain central repository for study findings Adopt best practices for contract management
Data and information are gathered	Gaps in outcome data; inadequate, fragmented and incompatible automated information systems	Improve LINK, as well as integrate all information systems Integrate findings information from all sources (inside and outside agency)
Data and information are analyzed	Minimal agencywide analysis; lack of capacity to use data gathered	Expand internal capacity for research and analysis Establish strong research relationship with academic/research institute partners
Analysis and information are used to make improvements	Fragmented; some positive developments (Area Office Quality Improvement teams, Risk Management and Decision Support Units, Behavioral Health Partnership service utilization and needs data) Trying to develop culture of results based decisions (ROM information system, research scientist on staff, use of logic models, Results Based Accountability participation)	Centrally collect all information produced; widely distribute results (all levels of agency, policymakers, stakeholders) Require formal response to results-based findings, recommendations Strengthen external accountability mechanisms (e.g., state, area, and facility advisory councils) and eliminate redundant/ineffective reporting

Study Limitations. The PRI staff was unable, within the study time frame, to completely assess every effort to monitor and evaluate the Department of Children and Families. For example, while work force development and employee performance evaluation procedures have an important role in supporting quality improvement, the DCF human resources division, the department's Training Academy, and the agency's use of the Performance Assessment and Recognition System (PARS) were not evaluated. Another key department program, foster care, was undergoing a major restructuring at time of committee review. Nearly all aspects of foster care monitoring and evaluation are being revamped so PRI staff were limited in what could be assessed as it is too soon to know the impact.

Report Organization

This report is organized into four sections. Section I presents committee findings and recommendations regarding DCF goals. Overall findings about the DCF monitoring and evaluation system are summarized in Section II. Section III makes findings and recommendations to improve the monitoring and evaluation system. The report concludes with Section IV, which synthesizes the information on data results achieved by the agency and its programs that was identified through the study's examination of the many DCF monitoring and evaluation efforts.

DCF Goals

Many goals have been established internally and externally for the Department of Children and Families. At this time, the department does not have a single document containing all goals for the overall agency, its mandate areas, or its specific programs. The information about DCF goals presented below was compiled from a variety of sources, including state statutes, agency plans and budget documents, mission and goal statements included on the agency's webpage, and interviews with agency staff.

Agencywide goals. The Department of Children and Families, like child welfare agencies in most states and at the federal level, has three main goals for children: 1) safety; 2) permanency; and 3) well-being. These goals, as well as the agency's mission statement and five guiding principles, are not specified in state statute, although they are implied in many of the laws directing DCF operations. Other agencywide goals are the 22 Positive Outcomes for Children that parallel the exit plan outcome measures established under the *Juan F.* child welfare consent decree, all of which are focused on safety, permanency, and the well-being of children and families.

The agency mission, guiding principles, and 22 outcome goals, which are summarized in Appendix B, are posted throughout the agency. The department developed a multi-year strategic plan for achieving its 22 Positive Outcomes for Children in 2004. A revised action plan focused on strategies for improving agency performance concerning two fundamental outcomes, meeting needs and appropriate treatment planning, was developed in May 2007.

However, despite a long-standing statutory mandate for agencywide strategic planning, there is no document that integrates the agency mission and the values represented in its guiding principles with outcome goals related to all DCF mandates. Some department staff are working on a project called the Accountability Framework that is intended to incorporate agency results, which are primary goals, indicators for those results, and the key practice and performance considerations related to them into one management document.

The time frame for completing this project has been postponed in order to concentrate on other key quality improvement initiatives underway within the agency. Among the most important is development of an internal qualitative case review process, which the agency anticipates implementing on a pilot basis over the next year. It is part of DCF's effort to prepare for the next federal Child and Families Services Review (CFSR), scheduled for the fall of 2008. An effective qualitative case review process also is considered essential for termination of judicial branch monitoring of compliance with the *Juan F.* consent decree.

Child protection mandate goals. The department's goals related to its children's protective services mandate are based on state statutory policy directives to protect children from abuse and neglect, plan for permanent placement, and provide comprehensive services to meet the needs of at risk children and their families, as well as child welfare goals set under federal legislation. Like its agencywide goal, DCF's main child protection goals are: safety; permanency; and well-being.

Specific child protection goals include the 22 outcome measures for the *Juan F.* exit plan and the closely-related federal outcomes standards for state child welfare agencies. These are also summarized, with all other major agency goals, in Appendix B.

As noted above, the department developed and has revised an action plan, with specific strategies and time frames, for achieving compliance with the *Juan F.* consent decree goals. Progress in implementing the plan is regularly assessed by department management as well as the court monitor. The *Juan F.* action plan also is incorporated in DCF's Child and Family Service Plan, developed in accordance with federal requirements, to outline the agency's child welfare goals and strategies for achieving them. Another document containing department child protection goals is its Performance Improvement Plan that must be prepared and implemented in response to federal Child and Family Services Review findings.

Behavioral health mandate goals. The goals of the DCF's behavioral health mandate, as defined in the agency's current budget document, are:

- to address children's behavioral health needs, serve children in their homes and communities to the greatest extent possible, and use the most effective, evidence-based practices in all behavioral health services.

Goals for the department's overall behavioral health system are not clearly set out in statute. However, expected outcomes for the state's major behavioral health reform initiative, the Connecticut Behavioral Health Partnership, and KidCare, the children's services component overseen by DCF, are described in state law. The KidCare statutory goals are included in Appendix B.

DCF participates in the statewide mental health planning process the Department of Mental Health and Addiction Services (DMHAS) carries out to meet federal mental health block grant funding requirements. DCF prepares the section of the federal plan on children's services, which must describe how the state will implement an organized, community-based system for improving mental health services for children with serious emotional disturbances.

In addition to describing the current state service system, the federal mental health plan must: identify and analyze system strengths, needs, and priorities; and discuss performance goals and action plans for improvement. Although goals and measures are outlined in the children's services section, the document does not appear to be used by DCF or its behavioral health bureau as a strategic guide for providing services.

A two-year strategic plan that sets goals for Riverview, the children's psychiatric hospital operated by DCF, was developed by facility staff with the help of the DCF Bureau of Continuous Quality Improvement (BCQI), in the spring of 2007. A multidisciplinary hospital staff workgroup is responsible for implementation, and progress is reviewed quarterly by facility management, a BCQI representative, and an on-site monitor from the Office of the Child Advocate.

Juvenile justice mandate goals. DCF's juvenile justice goals, as outlined on the agency's Juvenile Services Bureau website, are:

- to serve children in the juvenile justice system and their families; protect public safety; collaborate with the courts, communities, and partners; and provide a continuum of effective prevention, treatment, and transitional services children need to succeed in their families and communities.

Further, there are specific statutory goals for the state juvenile justice system, which apply to the courts as well as DCF. These are listed as well in Appendix B and are generally reflected in the juvenile services bureau goal statement.

A statewide juvenile justice strategic plan was prepared by the DCF Juvenile Services Bureau and the Court Support Services Division (CSSD) of the Judicial Branch with input from many public and private stakeholders and issued in August 2006. It sets a vision, mission, 10 guiding principles, and 12 broad system goals in four areas (resource development; coordination, collaboration, and information sharing; data analysis; and work force development).

At present, a workgroup of staff from the DCF Juvenile Services Bureau and the Court Support Services Division, advocates, and parents, with the help of a consultant, are operationalizing the statewide plan into a results-based accountability format. In addition, DCF and CSSD staff have jointly developed a plan for carrying out the goals of, and meeting the juvenile services outcomes required under, the final settlement agreement for the *Emily J.* class action lawsuit.

Staff of the Connecticut Juvenile Training School developed a strategic action plan for that facility in the summer of 2005. In addition to setting six main goals for improving programming and accountability, that plan: defined objectives and outcomes for each goal; included specific action steps for each one; and outlined implementation time frames and responsibilities. Progress was monitored and strategies were revised as needed on a monthly basis until the end of 2006. Strategic planning for CJTS has been put on hold pending a final decision about the facility's future.

Prevention mandate goals. State statute specifically includes prevention services as a DCF responsibility in providing comprehensive services to children and families at risk for abuse, neglect, delinquency, and behavioral health problems. The department's goals for its prevention mandate are set out in detail on the agency webpage and budget document. They are:

- promote a range of services that enable children and their families to thrive independently in their communities; and
- apply evidence-based or best practice prevention approaches to ensure successful transition from DCF involvement, or to prevent DCF involvement at all by children and their families.

The DCF prevention office also has adopted seven guiding principles that reflect and expand on the agencywide guiding principles (see Appendix B). Further, the department developed a five-year child welfare prevention plan in 2006 that outlines four goals related to primary prevention and early intervention efforts carried out by the agency. Progress is monitored by the prevention office director, who provides status reports as needed or on request to agency top management.

Major programs. Goals of each of the major department programs within each of the four mandated areas are also listed in Appendix B. The main source for program-specific goals is the agency's budget document. All of the more than 70 specific budgeted programs reviewed had goals, although they do vary in specificity, measurability, and relevance.

Many of the program goals are related to outcomes for children and families, usually in very broad terms (e.g., "foster positive youth development"), but a significant number primarily relate to how services are to be delivered (e.g., "receive appropriate services in the least restrictive setting"). Few of the program goals identified by PRI staff incorporate the agency's guiding principles concerning family-centered practice, partnerships, and cultural competence. For the most part, however, they are consistent with the agency's overall and mandate area goals.

Summary of findings. Specific, measurable, attainable goals are a critical first step for successful monitoring and evaluation efforts. Research on best practices for quality improvement in child welfare organizations shows that effective processes start with clearly defined outcomes. An accepted way to make both agency goals and the standards for programs and services explicit, is through one comprehensive strategic plan for meeting the needs of children and families.

The program review committee believes DCF needs to compile the goals guiding all of its programs and services into a single source as a first step in integrating the many expectations of the agency and ensuring desired results are clear and consistent. At present, there are some department goals that can be viewed as conflicting; for example, the national child welfare standards and *Juan F.* exit plan outcome measures concerning reunification can require strategies that seem at odds with the standards and measures of timely adoption.

The process of integrating all agency goals in one place would be an opportunity to address such issues. While it may not be possible to resolve every one, the challenges in carrying out DCF's broad mission will be better recognized. It will also make clear to all agency staff and to other agencies and the public what the department is trying to achieve.

The intention of the department's QI initiative called the Accountability Framework is to describe the outcomes the department seeks to achieve, and have a formal document that serves as a management tool and guide for accountability. However, if recent plans are followed, that project will not occur for at least another year.

Further, the department's comprehensive strategic plan mandate, which has a similar intent, has been on the books since 1979 and has never been implemented. Periodically, the department has prepared strategic planning documents that have partially addressed the requirements of state statute; however, no strategic plan, other than the action plan for the *Juan F.* consent decree, has been issued since 2000.

In addition, the department's policy manual section on its mission, values, critical issues, strategic goals, and department strategies has not changed since 1996. While it is not necessarily inaccurate, it does not reflect the agency's latest thinking or its current mission and vision. Also, the present driving force of the agency -- its 22 Positive Outcomes for Children -- is not represented in the policy manual, and there is still no official department policy on its behavioral health mandate.

A strategic planning document with clearly defined goals, relevant measures of progress, and well-developed action steps that reflect the full scope of the department's mission is an essential first step to improving the monitoring and evaluation outcomes of DCF programs and services. The significant improvements in agency practice and procedure that have occurred over the past three years in response to the *Juan F.* exit plan process are evidence of the success of this approach. Therefore, **the program review committee recommends:**

The current statutory provision for a Department of Children and Families biennial five-year master plan shall be repealed and replaced with a mandate for ongoing strategic planning. Specifically:

Beginning July 1, 2008, the department shall start the process of developing a vision, mission, and strategic goals with the advice and assistance of representatives of the children and families served by the agency, public and private providers, advocates, and other stakeholders.

The department should dedicate staff, under the direction of the commissioner or deputy commissioner, to: 1) prepare a strategic planning document that includes action steps and time frame for implementation to fulfill the vision, mission, and goals developed with stakeholders; 2) track and report on progress in achieving the plan's goals at least annually; and 3) regularly review, revise, and update the department's strategic plan as needed.

The first plan shall be completed and submitted to the legislature and the governor by July 1, 2009. The department's plan shall be submitted to the agency's Statewide Advisory Council for review and comment prior to submission to the legislature and governor. Progress in carrying out the plan shall be reported to the council by the DCF commissioner at least quarterly and to the legislature and governor annually.

Strategic planning is beneficial for any state agency and DCF is one of the few that has experience in developing a successful plan and process. The planning process recommended by the committee incorporates effective elements from the *Juan F.* exit plan process that ensure continuous review and updating. There are two major differences, however. First, the scope of this strategic planning process is agencywide; it includes all populations covered by DCF's broad mission. Unlike other plans developed by the agency, it should create a vision that consolidates the agency's goals for every mandate area and integrates services throughout the department that are designed to achieve them.

Second, the process requires strong participation from groups outside the agency. Stakeholders are expected to be partners, which is a central DCF value, in developing the agency's vision, mission and goals. A successful model for this type of inclusive and transparent planning is the process recently used to create the statewide juvenile justice plan.

Section II

DCF Monitoring and Evaluation System Assessment

The program review committee staff identified and analyzed four main sources of DCF monitoring and evaluation: internal efforts; external efforts; outside investigations and studies; and advisory groups established under federal or state law. Each source is summarized in Table II-1 and described in more detail below.

To assess the effectiveness of the DCF monitoring and evaluation system, the PRI committee staff analyzed the major internal, external, outside investigative, and advisory group efforts to track the agency's progress toward its goals. Figure II-1 summarizes these efforts, and the main activities of each source of agency oversight are briefly described.

The approach used by the committee staff to rate the many processes and products involved in these monitoring and evaluation efforts is also described. A summary of what was learned about the DCF accountability system follows.

The main purpose of the analysis was to identify strengths of the current monitoring and evaluation efforts and areas in need of improvement. Committee findings about what is working well and proposals to address deficiencies, gaps or redundancies are presented in the following section.

Internal Monitoring and Evaluation

Internal efforts by DCF to monitor and evaluate the progress it is making in achieving its program, mandate, and overall agency goals include a large number and wide range of activities. Major agency activities, which were described in the briefing report, are summarized briefly below. They include: the licensing, other quality assurance, and program review functions of the Bureau of Continuous Quality Improvement; performance-based contracting; child fatality and other critical incident special reviews; certain agency planning processes; and independent evaluations conducted on behalf of the department.

Licensure. The DCF Licensing Unit is responsible for assessing compliance with federal, state, and local regulations, laws, and ordinances. The Licensing Unit processes licensing applications (new and renewal), makes site inspections (scheduled and unscheduled), approves and monitors correction plans, and makes recommendations related to licenses, including temporarily closing admissions, reducing capacity, suspension of license, and revocation of license. There are five types of in-state licenses that the unit is responsible for including: child care facilities (i.e., residential treatment, residential education, temporary shelters, group homes, and SAFE Homes); extended day treatment; and out-patient psychiatric clinics for children (i.e., Child Guidance Clinics).

Internal program reviews. By law, the Department of Children and Families has been required since 1975 to “conduct studies of any program, service or facility developed, operated, contracted for, or supported by the department in order to evaluate its effectiveness.” (C.G.S. Sec. 17a-3(a)(6)). DCF conducts studies through the BCQI Program Review and Evaluation Unit

Figure II-1. Summary of Efforts to Monitor and Evaluate DCF

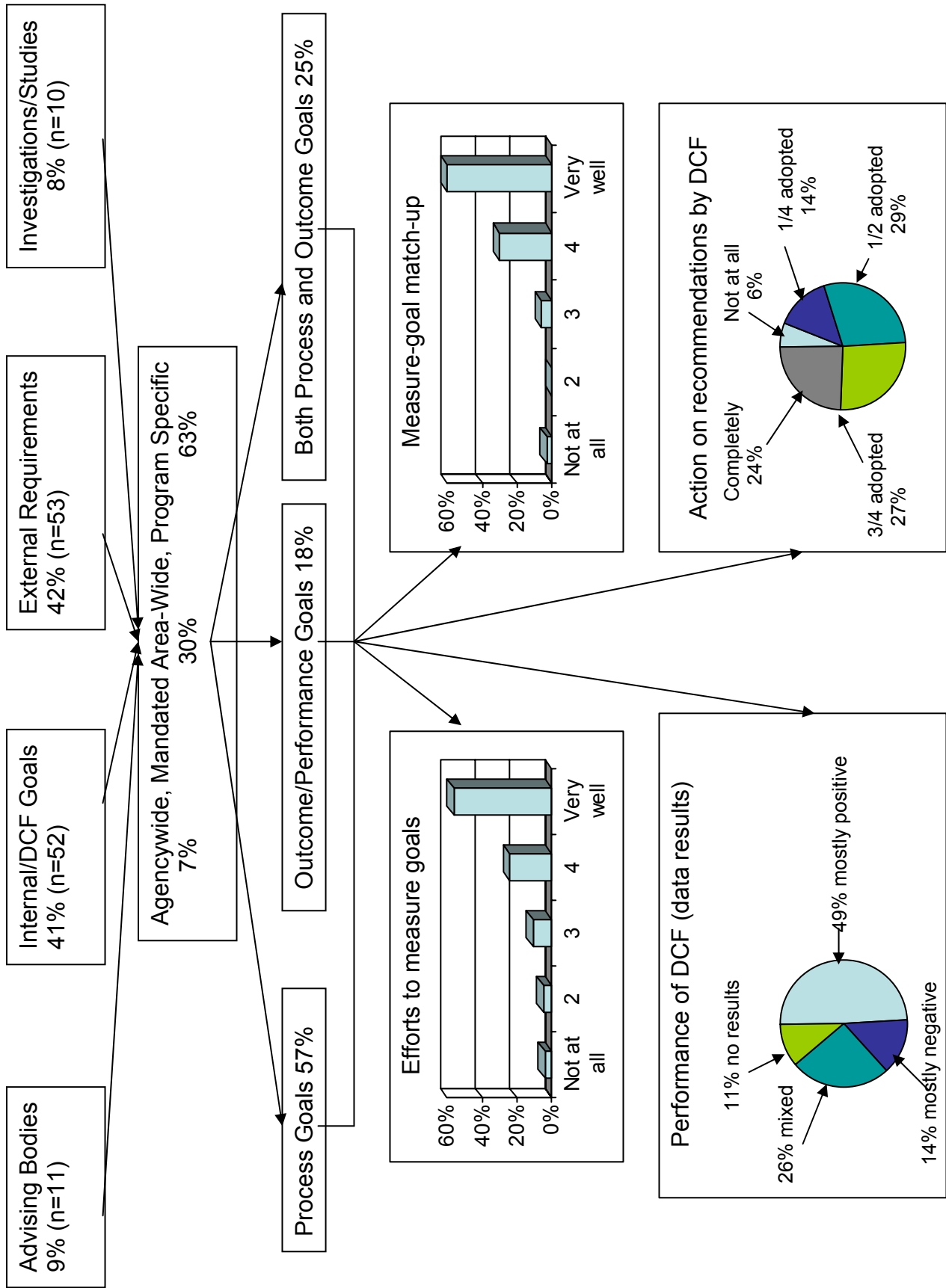


Table II-1: Current DCF Monitoring and Evaluation Efforts by Type

Internal Monitoring & Evaluation:

- DCF Bureau of Continuous Quality Improvement
- DCF performance-based contracting
- Internal child fatality and critical incident reviews
- Ombudsman's office

External Monitoring & Evaluation:

- Federal
 - U.S. Department of Health and Human Services
 - Children's Bureau of Administration for Children and Families (ACF)
 - Substance Abuse and Mental Health Services Administration (SAMHSA)
 - U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention (OJJDP)
- Judicial Branch/Court Monitors (e.g., *Juan F.* Court Monitor)
- Independent Accreditation Groups
 - The Joint Commission (hospitals)
 - Council on Accreditation (child welfare agencies)
 - Commission on Accreditation for Corrections (correctional facilities)
- Legislative
 - Committees of Cognizance
 - Results Based Accountability
 - Statutory reporting requirements

Outside Investigations/Studies:

- Office of the Child Advocate (OCA)
- Child Fatality Review Panel
- Office of the Attorney General

Advising Bodies (established under state or federal law):

- State & Area Advisory Councils
- Connecticut Juvenile Training School (CJTS) Advisory Group
- Connecticut Citizen Review Panel (required by federal law)
- Connecticut Behavioral Health Partnership Oversight Council

(PREU) as well as by program directors and program leads. Within the past three to five years, internal studies were conducted of CJTS, Extended Day Treatment programs, the Wilderness School, and Riverview Hospital.

Performance-based contracting. There are approximately 300 performance-based contracts managed by DCF to provide services to children and families. Within the standard contract template is a section pertaining to expected performance from the provider. Periodically,

the providers are required to report progress on meeting these service expectation goals. Fiscal performance is monitored by the Grants Development and Contracts Division, and program implementation is monitored by program leads within the each of the bureaus. The Program Review and Evaluation Unit, with the assistance of a vendor (Advanced Behavioral Health), aggregates provider-supplied information about the clients served, including demographics, length of service, and reasons for service discontinuation, into various quarterly reports.

Planning efforts. DCF is involved in several planning efforts that range from a particular facility's reform initiative to a child welfare prevention five-year plan. Area offices are required to prepare quality improvement plans and some facilities, such as CJTS, have developed strategic plans. Task forces may also produce plans, such as the permanency planning goals task force. Collaborative plans are sometimes developed with many partners. An example is a recent girls' services plan, prepared by DCF with other state agencies (CSSD, OCA, Permanent Commission on the Status of Women), advocates and private providers, for a continuum of community-based services for adolescent girls involved in the juvenile justice system and their families.

Internal child fatality reviews. In collaboration with the Child Welfare League of America, the Research and Development Unit within the Bureau of Prevention and External Affairs conducts internal child fatality reviews. These reviews are a way to evaluate the causes of such tragedies and include a case analysis of the facts (who, what, when, where, how). The research unit also examines what happened as it relates to practice, whether, for example, staff worked together as a team, etc. In recent years, the Office of the Child Advocate has also been invited to participate in this internal child fatality review.

Independent evaluations. The Department of Children and Families periodically uses outside organizations to supplement its internal evaluation resources and to obtain special expertise that cannot be found within the agency. Some of the outside evaluations commissioned by DCF have been required as a condition of federal funding or as part of the agreement for using a proprietary service model. Independent reviews of agency programs, such as the behavioral health KidCare program, also have been directed by the legislature. A description of the agency's recent contracted evaluations is provided in Appendix C.

Other facility/area office specific efforts. In addition to the internal monitoring and evaluation efforts that occur within each of the above areas, the DCF facilities and area offices also monitor and evaluate various aspects of their service delivery. Examples include critical indicators, restraint and seclusion incidences, Office of the Ombudsman facility complaints and inquiries, program lead site visits to providers, and area office or division monthly or quarterly progress reports on goals and activities.

External Monitoring and Evaluation

PRI staff also examined external monitoring and evaluation efforts. Seven types of ongoing oversight by entities outside the department, including the legislature, are summarized briefly below.

Juan F. court monitor. Under the 1991 consent decree from Connecticut's *Juan F.* child welfare system class action lawsuit, DCF is subject to monitoring and evaluation by a federal court monitor. Over the years, a series of corrective action agreements and revised monitoring orders developed by the parties and the monitor's office have guided agency efforts to comply with the consent decree. At present, an exit plan with 22 specific outcome measures adopted in 2004 is the focus of department activities to improve child safety, permanency, and well-being. Progress is regularly tracked, assessed, and reported by the *Juan F.* court monitor, as described in detail in the committee staff briefing report.

Other court monitoring. Settlement agreements from two other federal class action lawsuits, also described in the briefing report, have resulted in similar court monitoring and evaluation of certain DCF programs. Provisions of agreements regarding the *Emily J.* case reached in 2002 and revised in 2005, required the department and the Judicial Branch to jointly develop and carry out a corrective action plan to improve mental health services for children in the juvenile justice system. The independent court monitor responsible for reviewing compliance with the *Emily J.* agreement recently found satisfactory progress had been achieved and the case was closed by the court in October 2007.

The recently settled *W.R.* federal class action lawsuit also requires DCF to better address the needs of children and youth with serious behavioral health issues. The settlement agreement approved by the legislature in June 2007 requires the agency to expand appropriate community-based mental health services and other supports for these children and their families. Implementation of the agreement will be monitored by an outside consultant agreed upon by the parties.

Federal grant evaluation requirements. In addition to the general funding provided to DCF by the Children's Bureau of the U.S. Department of Health and Human Services, federal grants for specific purposes have been awarded to the agency. Multi-year grants from the federal government often requires an external evaluator assess progress in implementing the grant-funded program and expected outcomes. Monitoring of these grants by the federal government occurs through site visits and requirements to submit data on progress on a quarterly/annual/periodic basis. Appendix D provides a description of current DCF federal grant funding.

Federal child welfare national outcome standards. National child welfare standards are based on a state's results on the federal Child and Family Services Reviews. There are six standards in the following areas related to expected child safety and permanency outcomes: 1) repeat maltreatment; 2) maltreatment of children in foster care; 3) foster care re-entries; 4) length of time to achieve reunification; 5) length of time to achieve adoption; and 6) stability of foster care placements. A comparison of these national outcome standards with the *Juan F.* Consent Decree Exit Outcomes is provided in Appendix E.

Other federal review requirements. The DHHS Children's Bureau monitors state child welfare services through a series of reporting systems, reviews, and annual federal reports. Connecticut participates in the adoption and foster care reporting system (AFCARS) and the child abuse and neglect data system (NCANDS). Connecticut also is subject to assessments that verify: submitted electronic data matches the information in paper files (AFCARS Assessment

Review); foster care eligibility is accurate (Title IV-E Foster Care Eligibility Reviews); and the state's automated child welfare information system (LINK) meets federal requirements. Federal reports are produced on child maltreatment, and the national child welfare outcomes. A full description of federal government monitoring and evaluation of DCF is found in Appendix F.

Accreditation, DPH licensure, and Medicaid requirements. External approvals are given to Riverview Hospital through its accreditation by the Joint Commission, and to the Wilderness School through licensure by the state Department of Public Health. Additionally, through a Medicaid provider and billing agreement between DCF, DSS, and private providers, Connecticut is eligible to receive up to 25 percent reimbursement from the federal government for allowable group home and residential treatment costs under the Connecticut Medicaid Private Non-Medical Institution program (PNMI).

The PNMI program has requirements for services that must be met in order to receive reimbursement, including a requirement that an individualized treatment plan be developed within 30 days of admission, and that specific behavioral health goals and objectives are included within every treatment plan. A full description of DCF's accrediting bodies--the Joint Commission, Council on Accreditation, and the Commission on Accreditation for Corrections--is found in Appendix G. More information about PNMI, DPH and other state regulatory monitoring and evaluation efforts may be found in Appendix H.

Legislative oversight. The General Assembly's committees of cognizance over the Department of Children and Families include the Human Services and Judiciary Committees, as well as the Select Committee on Children. These committees have ongoing authority for monitoring and evaluating the department's performance and compliance with legislative intent. The program review committee, as part of its legislative oversight mandate, has conducted a number of evaluations of DCF and its mandate areas.

Additionally, the legislature oversees and assesses DCF and other state agencies through the appropriations process. The appropriations committee's recently established Results Based Accountability (RBA) project, in particular, is focused on monitoring and evaluating the progress agencies are making in achieving their policy and program goals.

Finally, as another mechanism for tracking agency progress in meeting its goals, DCF is required by law to provide a number of reports and plans to the legislature. Overall, more than a dozen different plans and reports about the department, including but not limited to a biennial, agencywide master plan, an annual report on CJTS, and an annual assessment of the Behavioral Health Partnership must be prepared and submitted in accordance with state statute. More information on legislative oversight can be found in Appendix I.

Outside Investigative Monitoring and Evaluation Efforts

The Office of the Child Advocate (OCA) was established in 1995 as an independent entity with broad authority to investigate and assess services provided to children and families by DCF and other state agencies. In addition, the state Child Fatality Review Panel (CFRP), which the child advocate currently chairs and helps staff, was created in the same year to review the deaths of children who are in out-of-home care or that involve unexpected or unexplained

causes. The CFRP reviews are aimed at developing prevention strategies and improving coordination of public services for children and families.

Under the state “whistleblower” law, the Office of the Attorney General has investigatory responsibilities concerning reports of mismanagement or misconduct occurring in any public agency including DCF. In recent years, the attorney general has issued investigative reports on five matters related to DCF based on whistleblower complaints, all of which were carried out in conjunction with the Office of the Child Advocate. The oversight roles of all three organizations concerning DCF are summarized in Appendix J.

Advising Bodies Monitoring and Evaluation of the Department

As noted in the September briefing report, a number of committees, commissions and boards, established in accordance with state and federal law, have responsibility for advising and assisting DCF on a variety of matters. Advisory groups provide an external perspective on issues and areas needing improvement. They often are a source of both formal and informal recommendations for changes in a state agency’s policies, programs, and services. Additionally, advisory activities can provide a forum for stakeholders to hold an agency accountable for results. For more detail on Advising Body activity, see Appendix K.

PRI Staff Assessment Approach

PRI staff gathered documentation related to DCF monitoring and evaluation efforts by internal, external, outside investigation, and advisory body sources. Specifically, reports and other materials demonstrating monitoring and evaluation efforts that occurred within the past three to five years through to September 2007 were reviewed.

In order to assess the efforts, PRI staff answered the questions shown in Table II-2 for each item reviewed, using an internally developed standardized rating system. The ratings required agreement between two PRI staff who had independently reviewed the items and then met to discuss their ratings.

The analysis in this section is based on the scores and descriptions resulting from this methodology. There are several limitations to the analysis. First, PRI staff was unable, within the study time frame, to completely assess every effort to monitor and evaluate the Department of Children and Families. In addition, not every activity or product, (e.g., licensing visit report, quality improvement plan, advisory meeting, report, etc.) could be examined. However, the PRI committee believes that the statistical reports, studies, and other documents reviewed are representative of the majority of monitoring and evaluation currently underway.

There were also situations where multiple monitoring and evaluation efforts were overlapping or occurring simultaneously. This made it difficult to discern which effort led to changes in programs or facilities, particularly when recommendations were similar. Another challenge is attributing outcomes to particular programs, especially when children and families are receiving a variety of services and supports at the same time.

Table II-2. Areas Assessed in Each Monitoring and Evaluation Document

Question Areas¹	Description
Is the focus of the monitoring and evaluation on DCF agencywide goals, mandated areas, or specific programs?	PRI staff identified the purpose of each monitoring and evaluation effort.
What is tracked: process (service delivery), outcome (end result) or both?	PRI staff classified monitoring and evaluation as: 1. “process only” for those efforts that pertained to the way in which service is delivered; 2. “outcome only” for those efforts that addressed expected end results or outcomes of the service; or 3. “both process and outcome” for efforts that addressed both aspects of monitoring and evaluation.
Are the goals and issues studied S.M.A.R.T.?	The stated goal(s) or issue(s) subject to the specific monitoring and evaluation effort was rated on whether it was: specific, measurable, attainable, relevant, and trackable (“S.M.A.R.T.”). On a scale from 1 to 5, where 5=very positive.
How well do the measures used match up with the goals?	The measures selected to assess progress on reaching the goal were rated on their logical relationship to the goal (versus chosen for convenience/ready availability). On a scale from 1 to 5, where 5=very well.
How good a job was done in collecting information to answer the question or ascertain progress in attaining the goal?	Examining the mechanical efforts to obtain information to address the goal or issue, PRI staff rated monitoring and evaluation efforts on the extent to which measures were consistent, with good quality data and little or no missing information. On a scale from 1 to 5, where 5=the <i>goal</i> is measured consistently, with good quality data and little or no missing information, or the <i>issue</i> or question is clearly addressed, with good quality data or sources of information.
Were the monitoring and evaluation findings used to make changes?	Step 1: PRI staff assessed whether the findings addressed organizational barriers, communication barriers and/or resource barriers. Step 2: Through interviews, PRI staff determined if the monitoring and evaluation findings were used by DCF to make changes to policy, to training, or to services, or if legislative changes were made. On a scale from 1 to 7, where 1=no findings were used, to 7= findings were fully used to identify organizational and resource barriers and to make changes to policies, training and services, and used to seek legislative changes.
Were the recommendations stated clearly, did they flow logically from the findings, and did they contain actions?	Based on the reviewed documents recommendations were rated on a scale of 1-5, where 5=very positive.
Were the recommendations adopted?	Based on interviews and available documents, PRI staff estimated the percent of recommendations that were adopted. On a scale from 1 to 5, where 1=not at all, to 5=completely.

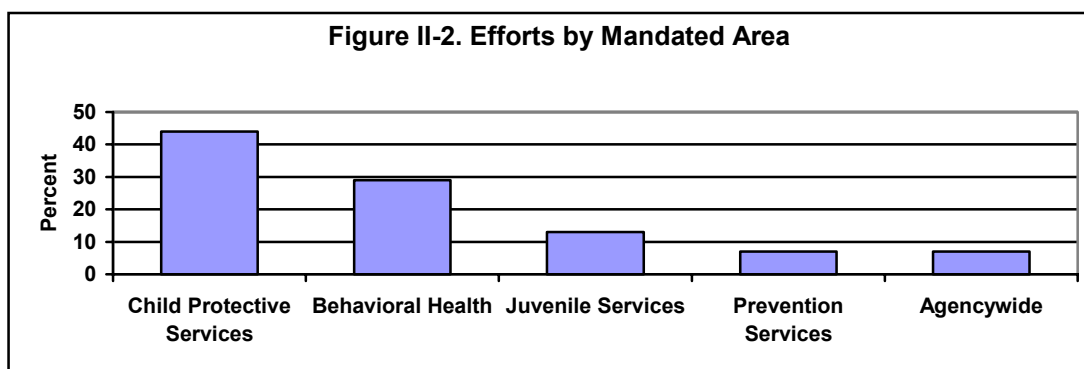
¹ In addition to these questions, PRI staff looked at how the data were collected and then analyzed. A summary of the information can be found in Appendices L, M, N, and O.

Lastly, the rating system does not capture the magnitude of a particular monitoring and evaluation activity. The committee staff did not try to assess the significance of the efforts or of the recommendations made by oversight entities or adopted by DCF. Staff calculated only the percent of recommendations adopted by DCF, and did not attempt to rate their importance.

Key Findings

Is the focus of DCF monitoring and evaluation on agencywide goals, mandated areas, or specific programs? *The PRI committee found that the focus is not on agencywide goals, as just 7 percent of all the efforts examined applied to the department overall. However, the PRI committee found when analyzing only investigative monitoring and evaluation efforts, the focus is on agencywide goals at least 40 percent of the time. Nearly one-third of efforts concerned a general mandated area (31 percent), most often child protective services (82 percent). The remaining two-thirds of efforts were for specific programs within the various mandated areas.*

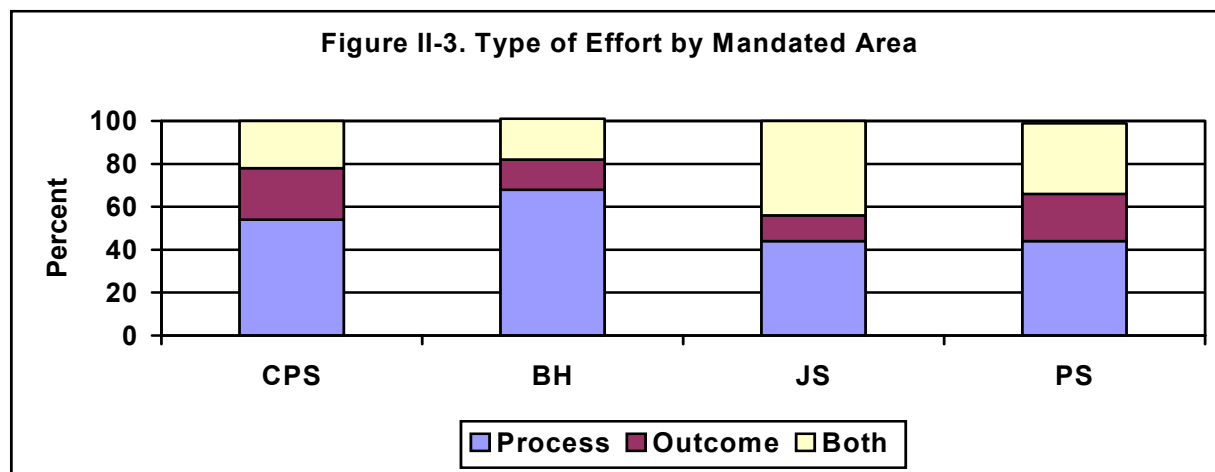
Figure II-2 provides a breakout of the monitoring and evaluation efforts when programs are grouped within their respective mandated areas. Nearly half of the monitoring and evaluation efforts examined in this study are within the child protective services category (44 percent), followed by the behavioral health services category (29 percent). Little attention is given to prevention services mandate area.



What is tracked: process (service delivery), outcome (end result) or both? The PRI committee found that *more than half of all monitoring and evaluation efforts focus solely on process goals or issues (57 percent of efforts)*, with progress on goal attainment limited to the delivery of service to the exclusion of outcome or impact. *On the other hand, one-quarter (25 percent) contain both process and outcome goals or issues, and 18 percent focus solely on outcomes.*

Figure II-3 shows the type of effort for each of the mandated areas. The highest proportion of process monitoring and evaluation occurs within the behavioral health mandated area (68 percent). Combining the “outcome only” and “both process and outcome” categories,

the greatest proportion of monitoring and evaluation of outcomes occurs within the juvenile services mandated area (56 percent).



Are the goals and issues studied S.M.A.R.T.? On a scale from 1 to 5, where 5=very positive, the goals and issues subject to monitoring and evaluation efforts had the following average ratings:

- Specific=4.40
- Measurable=4.40
- Attainable=4.56
- Relevant=4.87
- Trackable=4.73

Based on the results of the S.M.A.R.T. ratings, *overall, monitoring and evaluation goals or study questions are specific, simple, concise, and clearly understood*. Achievement of the goals is readily measurable and results interpretable. Further, the goals are realistic and within reach, and the issues or questions can be readily answered by the monitoring and evaluation effort. The goals and issues studied also are highly relevant to the accomplishment of the agency or program mission and progress can be readily tracked over time. Thus, *overall, the goals and issues studied are stated in a way that lends them to being readily monitored and evaluated*.

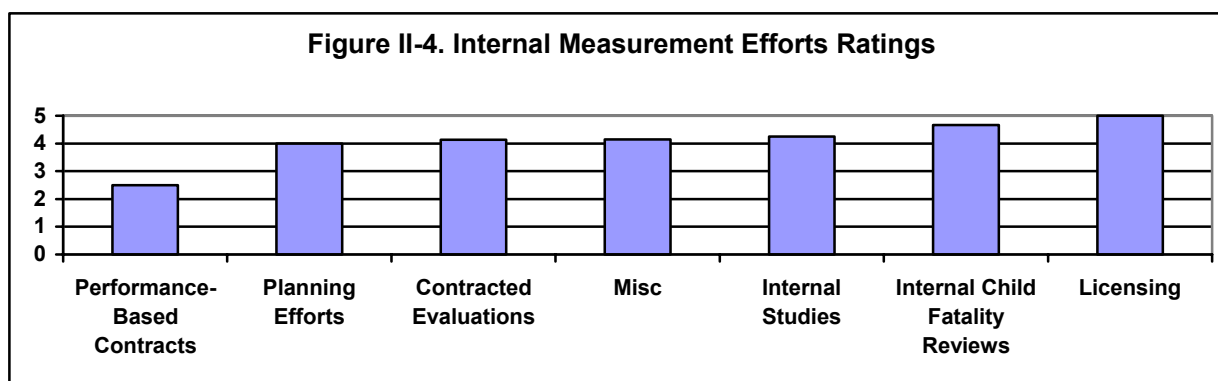
Two exceptions were found to the overall rating of goals and issues. *Goals or issues that were the subject of outside investigative monitoring and evaluation efforts were found by the PRI committee to have mixed ratings on measurability*. The measures were not specified or sometimes open to interpretation (e.g., “adequate”), and baseline data were missing. Additionally, the goals and issues monitored and evaluated by *advising bodies generally were found to be weak in specificity and measurability*.

How well do the measures used match up with the goals being monitored and evaluated? The PRI committee found an average 4.46 rating. This is interpreted to mean that *the measures employed by the monitoring and evaluation efforts are both comprehensive and*

logically related to the goal. Study questions are logically related to the study approach and addressed comprehensively.

How good a job was done in collecting information to ascertain progress in attaining goals or answer the study question? The PRI committee rated this attribute as 4.24. This is interpreted to mean that, in general, the information collected through monitoring and evaluation efforts is of good quality with little missing information.

However, there were differences in this rating depending on the type of monitoring and evaluation efforts. Figure II-4 shows that within the category of internal monitoring and evaluation, performance-based contracts had the poorest measurement efforts and licensing the best measurement efforts.



Were the monitoring and evaluation findings used to make changes? There was no statistically significant difference in the use of findings depending on the source of monitoring and evaluation.

Table II-3 shows that *measurement findings were most often used for changes to services to children and families, identification of organizational barriers, and identification of resource barriers. Conversely, measurement results were least often used for seeking legislative changes.*

Use	Number
Services to children and families	86
Identification of organizational barriers	77
Identification of resource barriers	71
Policies	64
Training	63
Legislative	13
Source: LPR&IC.	

Were the recommendations stated clearly, did they flow logically from the findings, and did they contain actions? Not all monitoring and evaluation efforts contained recommendations. Of the 126 examined by PRI staff, slightly less than half contained recommendations (47 percent). Investigations/Studies have the most recommendations (90 percent) and external efforts the least (26 percent). Noteworthy is that not all advising bodies have recommendations, despite their charge to provide recommendations to the department.

Were the recommendations adopted? Examining the recommendations from monitoring and evaluation efforts, PRI staff estimated the percent of recommendations that were adopted. On a scale from 1 to 5, where 1=not at all, to 5=completely, the average rating was 3.49. This rating is interpreted to mean that between 50 to 75 percent of the recommended changes were adopted per monitoring and evaluation effort. Additionally, the percent of recommendations adopted from external sources were significantly greater than the percent of recommendations adopted from investigations/studies (3.83 vs. 2.86).

Assessment Summary

Current efforts are concentrated primarily within child protective services and behavioral health services. As seen in Table II-4, these two areas represent the largest investment by DCF, serving the greatest number of clients, and receiving the largest allocation of financial resources. Less attention is given to juvenile services and prevention and little agencywide monitoring and evaluation occurs.

The emphasis of the current monitoring and evaluation system is on process or how services are delivered. It is important to assess service delivery as well as outcomes for children and families. Both pieces of information are valuable. To replicate a program with positive outcomes, for example, one would need to have a good understanding of the service delivered and aspects of the program that are viewed favorably. However, whether services are having their intended effect and meeting children's needs must be given more attention. The court monitor, the child advocate, and federal reviewers have all made this finding.

The goals and issues chosen to be studied are stated in a way that lends them to being readily monitored and evaluated. They tend to be specific, simple, concise and clearly understood. Exceptions are: the lack of specificity and measurability of advising bodies' goals or purpose; and the measurability of the subjects of outside investigative monitoring.

Overall, the measures match up with the goals; they are logically related and not chosen simply for ease measurement. In general, the information collected is of good quality with little missing information. One exception is the poor measurement efforts found for performance-based contracts.

The monitoring and evaluation findings tended to be used by DCF most frequently to make changes to services to children and families, and to identify organizational and resource barriers. In general, between 50 to 75 percent of recommended changes from monitoring and evaluation efforts were adopted.

TABLE II-4. PROGRAM FUNDING AND SELECTED CLIENT INFORMATION: FY 06

MANDATE AREA		KEY PROGRAMS	EXPENDITURES (IN MILLIONS)	SELECTED CLIENT INFORMATION
AGENCYWIDE			\$ 754.9	
CHILD PROTECTIVE SERVICES			\$ 395.0	
		<ul style="list-style-type: none"> <u>Community Based Services</u> <ul style="list-style-type: none"> ▪ Hotline ▪ In-Home (family preservation, parent aide, substance abuse screening) 	\$ 33.9	<ul style="list-style-type: none"> - 43,500 reports of abuse/neglect received; 7,568 reports substantiated - 3,400 families received in-home child protection services
		<ul style="list-style-type: none"> <u>Out of Home Services</u> <ul style="list-style-type: none"> ▪ Foster Care, Adoption. Subsidized Guardianship, Relative Caregivers, Independent Living, SAFE Homes, Shelters 	\$ 203.1	<ul style="list-style-type: none"> - Averaged 3,216 children in foster care - 1,210 children living with licensed relative caregivers - Over 700 youth in independent living situations - Finalized 498 adoptions
		<ul style="list-style-type: none"> <u>Area Offices</u> 	\$ 157.9	<ul style="list-style-type: none"> - Total caseload: 17,770 (as of 6/06)
CHILDREN'S BEHAVIORAL HEALTH SERVICES			\$ 259.1	
		<ul style="list-style-type: none"> <u>Community Based Services</u> <ul style="list-style-type: none"> ▪ KidCare (Emergency Mobile Psychiatric, Intensive in-home treatment, Outpatient Clinics, Extended Day Treatment) 	\$ 66.2	<ul style="list-style-type: none"> - Community service capacity about 2,000 children
		<ul style="list-style-type: none"> <u>Out-of-Home Services</u> <ul style="list-style-type: none"> ▪ Residential Treatment, Therapeutic Group Homes 	\$ 133.6	<ul style="list-style-type: none"> - 874 in residential treatment
		<ul style="list-style-type: none"> <u>State Operated Facilities</u> <ul style="list-style-type: none"> ▪ Riverview Hospital ▪ High Meadows ▪ Connecticut Children's Place (CCP) 	\$ 52.3	<ul style="list-style-type: none"> - Riverview's average daily census about 80 children - High Meadows serves about 110 children/year - CCP serves approximately 150 children/year
JUVENILE SERVICES			\$ 58.1	
		<ul style="list-style-type: none"> <u>Community Based</u> <ul style="list-style-type: none"> ▪ Parole Services, Aftercare for Delinquent Youth 	\$ 13.3	<ul style="list-style-type: none"> - About 1,200 delinquent youth committed to DCF for out-of-home care annually
		<ul style="list-style-type: none"> <u>Out of Home Placement</u> <ul style="list-style-type: none"> ▪ Residential Treatment for Delinquent Youth 	\$ 16.8	<ul style="list-style-type: none"> - Approximately 500 parole cases in 2006
		<ul style="list-style-type: none"> <u>State Operated Facility</u> <ul style="list-style-type: none"> ▪ Ct. Juvenile Training School (CJTS) 	\$ 23.7	<ul style="list-style-type: none"> - CJTS average daily census about 100 boys
PREVENTION SERVICES			\$2.7	
		<ul style="list-style-type: none"> <u>Fund/directly provide various primary prevention programs</u> (e.g., child abuse prevention, positive youth development; early childhood services, diversion projects; public awareness campaigns) 	\$2.1	<ul style="list-style-type: none"> Served approximately 8,000 (does not include those reached through public awareness campaigns)
		<ul style="list-style-type: none"> <u>State Operated Facility</u> <ul style="list-style-type: none"> ▪ Wilderness School 	\$0.6	
			\$ 40.0	
AGENCY MANAGEMENT				
Sources of Data: Governor's Budget, FY 08-09; DCF				

Children and families benefit when findings and recommendations from effective monitoring and evaluation are used to better meet their needs. Positive changes in programs and services have resulted, for example, from the *Juan F.* Consent Decree, the *Emily J.* Settlement Agreement, DCF's licensing activities, and federal grant evaluations. Regardless of whether the feedback is positive or negative, it can help the agency improve its performance.

Finally, multiple monitoring and evaluation efforts provide a more complete understanding of a program, mandate area, or the agency as a whole rather than relying on a single source. Perspectives from outside the agency combined with internal monitoring and evaluation information provides a more comprehensive picture of DCF performance.

What the committee study reveals most clearly about the DCF monitoring and evaluation system is the fragmentation of current efforts and a lack of integration of the feedback produced. DCF needs to ensure all findings information comes together and is analyzed so patterns of deficiency can be identified and best practices can be shared.

This appears to be a main role for the agency's Risk Management Unit, but it has only three staff who at times are diverted from this task by other projects. Further, the structure of this unit, like another that supports results-based management (the Decision Support Unit), have been unsettled since the PRI study began. Roles and reporting relationships are still evolving and vacancies remain in the key management positions.

At present, the department's Service Evaluation and Enhancement Committee (SEEC) is the central mechanism for tracking available results information to "red flag" patterns of poor performance or undesirable outcomes. Another SEEC role is to identify issues that require proactive intervention from areas throughout the agency. This committee includes: all the agency bureau chiefs, a representative of the commissioner, and managers from various offices and units including policy, licensing, Program Review and Evaluation Unit, contracts, the ombudsman, and Hotline.

SEEC meets every two weeks to look at aggregated critical incident data, significant events, and other program information (e.g., ombudsman complaints, staff turnover rates, providers with financial trouble) compiled by Risk Management Unit staff. With the help of that staff, it looks at trends, identifies problem programs or providers, and develops ways to take corrective actions as early as possible.

While the idea is to have all areas of the department that are needed to address critical issues participating in this monitoring and evaluation process, in practice, key staff are often missing. Furthermore, the PRI committee found committee efforts have concentrated on emergency situations with private providers. **The program review committee recommends:**

the department should reinforce and expand the role of the Service Evaluation and Enhancement Committee in integrating monitoring and evaluation efforts across the agency and initiating proactive intervention on agencywide issues.

In addition to integrating efforts to avert and solve performance problems of private providers, SEEC or a similar mechanism, should be identifying and addressing issues that go beyond the jurisdiction of a single bureau or program. One example of an issue greatly in need of an agencywide consolidated approach within DCF and with other agencies is girls' services.

Strengthening the agency's capacity for integrating results data, in combination with the strategic planning initiative recommended earlier, will bring DCF much closer to the effective monitoring and evaluation system outlined by the national resource center framework noted in the report introduction. The core components of the framework represent nationally recognized best practices for monitoring and evaluation. By adopting such practices, DCF can be more effective in meeting the needs of the children and families its serves.

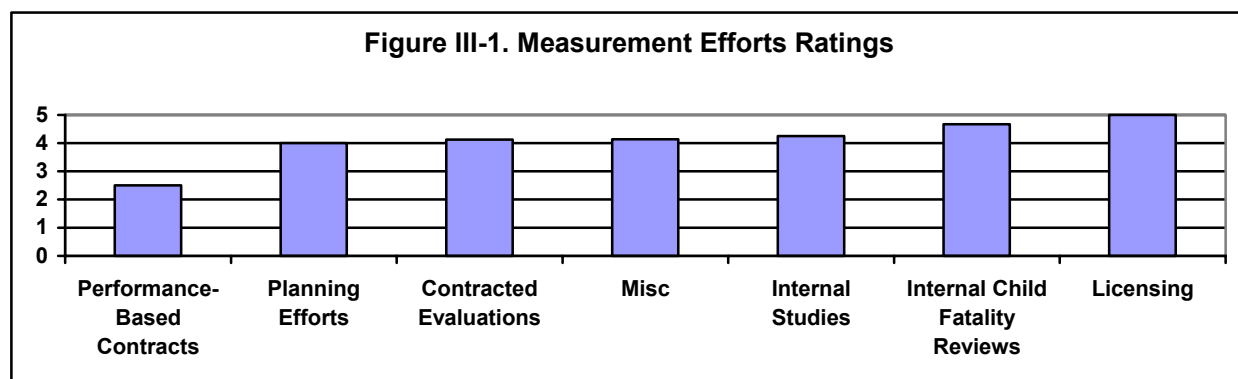
Section III

Findings and Recommendations on the Monitoring and Evaluation System

This section focuses on findings and recommendations to improve the system used by internal, external, investigative, and advising bodies to monitor and evaluate the department. The section concludes with DCF information systems findings and recommendations.

Internal Findings and Recommendations

Information collected. In general, the information collected for internal monitoring and evaluation efforts is of good quality with little missing information. However, there were differences across the different types of internal monitoring and evaluation efforts. Figure III-1 shows that *performance-based contracts had the poorest measurement efforts and licensing the best measurement efforts.*



Issues with measurement for performance-based contracts were that only the number of participants and demographic information was provided in the quarterly reports, and all other data were missing or not reported for many of the contracts. The only outcome measure included in the quarterly report is “reason for service discontinuation” which is inaccurate/incomplete, and is part of the data “scrubbing” currently underway. It is unclear how success would be determined, and how DCF would know whether the goals were attained.

Further, there were instances when data requirements were specified in contract, but not submitted regularly by the provider. In the few instances where requirements were specified in contract, the target or goal to be attained was not specified. For example, a contract for emergency mobile services requires the provider to submit client outcome data on functioning and symptom relief, but does not specify a percent or degree of improvement goal. Conversely, a contract for extended day treatment services requires the provider to meet performance standards such as “80 percent of children/youth will not require placement in a more restrictive setting” and “75 percent of children/youth will maintain or increase their school attendance.” **Therefore, the program review committee recommends:**

DCF performance-based contracts should specify the data required from providers. Performance standards or expected outcomes should be stated in the contract. DCF should monitor data submissions for accuracy.

The department has recognized the need to make expectations for provider performance more explicit and based on relevant research and recognized quality standards. To accomplish this objective, the agency, in partnership with providers, has started to implement a logic model approach for contract development. The PRI Committee believes using this model, which is a systematic method of linking program activities to desired outcomes can improve contract monitoring and evaluation efforts as recommended.

In other instances, data was submitted by providers and DCF took no action to review, aggregate, or analyze the information. Data that is time-consuming for providers to collect may not be summarized or analyzed because it is not needed or necessary information. **Therefore, the program review committee recommends:**

DCF should review currently required data elements from providers and determine whether they are necessary or analyzed in any way. Data elements that are unnecessary should be eliminated and additional data elements that pertain to outcomes should be added to performance-based contract requirements.

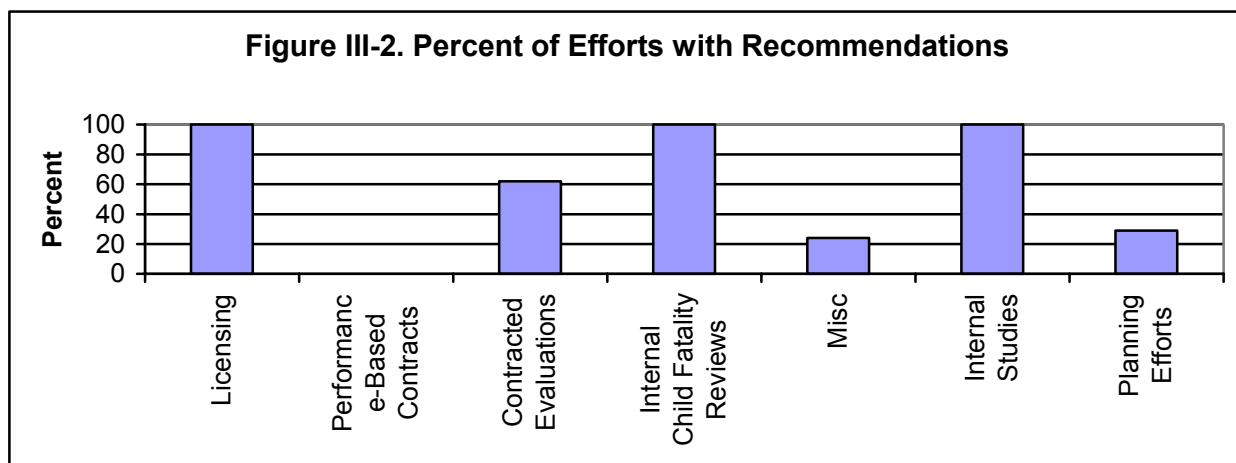
Additionally, data that are determined to be necessary, and required as such in provider contracts, should be summarized and analyzed by DCF. The department has currently chosen not to use information collected from some automated systems due to reliability concerns. While an accurate automated system would be ideal, until such a system exists, monitoring and evaluation of contract requirements can and must be done manually.

There is currently little accountability and knowledge of whether a provider is meeting contract expectations, and rarely are there consequences should this information be known by DCF. In a few instances, the Program Review and Evaluation Unit has prepared some comprehensive reports on residential treatment centers based on the data required from provider contracts on service delivery and effectiveness for each child in care. These useful reports, which are not shared with providers and appear to receive limited attention from within the department, include information on placement at discharge, change in functioning/GAF score, reason for discharge, and discharge status. **Therefore, the program review committee recommends:**

DCF shall compile necessary required data elements to compare actual and expected outcomes based on the performance-based contract. Failure to meet contract expectations should result in discussion and joint plans for progress in meeting expectations.

Until automated systems are deemed reliable, DCF should monitor contract expectations manually. Summary reports should be shared with providers so that they may monitor their performance against the aggregated data. Reports should be distributed to providers and DCF staff made more aware of the existence of these reports.

Recommendations. Not all internal monitoring and evaluation efforts contained recommendations. Of the 52 examined by PRI, slightly more than half contained recommendations (54 percent). Figure III-2 shows the percent of monitoring and evaluation efforts containing at least one recommendation.



As would be expected, performance-based contracts have no recommendations. On the other hand, all licensing efforts, internal studies, and internal child fatality reviews examined had recommendations. Surprisingly, one-third of the contracted evaluations paid for by DCF did not contain recommendations. The PRI committee believes that recommendations that logically flow from a study's findings are a key ingredient to subsequent changes or improvements.

Contracted evaluations. There is some confusion and concern regarding what happens to recommendations received by the department. This study found that a substantial proportion of recommendations are adopted; however, this information is not necessarily known or shared across divisions of DCF or with contracted evaluators. A formal process would be useful whereby DCF recommendations are reviewed and determinations made about their adoption or if not adopted, the rationale for that decision. This function does not currently exist. Further, there should be a formal tracking system to monitor implementation of recommendations and the occurrence of any anticipated outcomes as a result of adopting the recommendation. A good practice would be for DCF to review and formally respond to contracted evaluation reports, including adoption or rejection of recommendations. Through quarterly reports, DCF should monitor the implementation of recommendations and progress in achieving any anticipated outcomes as a result of adopting recommendations.

Evaluation library. Additionally, with staff turnover and changes in assignments, previous monitoring and evaluation efforts including study recommendations are not always known by staff who could benefit not only from the recommendations, but knowing the results of previous studies. There is no central repository for study reports currently. Because knowledge of previous efforts, results and recommendations would be both inexpensive to do, and beneficial to many, the **program review committee recommends:**

A central repository should be created by DCF of contracted research and evaluation reports and internally produced research and evaluation reports. This repository should be accessible and searchable by all DCF staff and should include the OPM feedback form as applicable.

Strengths. The internal monitoring and evaluation performed by DCF has a number of strengths. The *licensing function* is organized and effective. Forms and protocols are well documented. Monitoring via site visits to facilities and programs occurs regularly, and any deficiencies require correction before a license will be reissued.

The DCF licensing unit does a thorough and effective job of inspecting provider facilities and programs that fall within their purview. Of the DCF-run facilities, Riverview Hospital is accredited by the Joint Commission and CJTS is preparing to become accredited by the American Correctional Association. The Wilderness School is licensed by the Connecticut Department of Public Health. While there is consideration of DCF accreditation by the Council on Accreditation (COA), there is currently no accrediting or external licensing body reviewing High Meadows and Connecticut Children's Place. Therefore, until COA accreditation of DCF occurs, the **program review committee recommends:**

The DCF licensing unit should expand internal, self-monitoring by inspecting High Meadows and Connecticut Children's Place, the two DCF facilities not currently under external licensure or accreditation. The licensing unit should follow the child care facilities regulations standards used to inspect external residential treatment facilities similar to High Meadows and Connecticut Children's Place.

Another strength within the internal monitoring and evaluation performed by DCF is the *internal special review process* for child fatalities and other critical incidents conducted jointly by the DCF Director of Research and Development and the Child Welfare League of America. In interviews conducted for this study with a variety of agency staff and external organizations, including the Office of the Child Advocate, PRI staff was told repeatedly the recently redesigned special review process is a significant improvement over the prior system, and addresses very difficult events in a positive, objective, and supportive manner. It is also one of the few efforts that examine agencywide goals and performance throughout the department.

The special review effort could be strengthened further by requiring a formal response from the Commissioner regarding recommendations from the internal child fatality review. A forum for discussion that includes all relevant managers and area office directors would further expand the lessons learned philosophy of the process. Follow up of recommendations should be monitored by quality improvement staff, and be an automatic agenda item for quality improvement team meetings. **Therefore, the program review committee recommends:**

The department should establish an internal written policy for responding to recommendations from the internal special reviews of child fatalities and other critical incidents. The policy should require a corrective action plan be developed, implementation of accepted recommendations be monitored, and a status report be prepared for the commissioner every 90 days. A forum to discuss results and lessons learned should be scheduled with managers and key staff from all relevant areas of the department within 45 days of release of the report.

An additional monitoring and evaluation system strength revealed by the PRI study is the effective research relationship the department has developed with the *Child Health and Development Institute (CHDI)* and its affiliate, the *Connecticut Center for Effective Practice (CCEP)*. For a number of years, CHDI and CCEP have provided high quality, timely feedback on the effectiveness of a wide variety of children's behavioral health services funded by the Department of Children and Families. The department has used the results of the work of the institute and the center to improve program operations and the effectiveness of mental health and substance abuse services for children and families across the state.

At present, CHDI and the center provides a broad scope of evaluation services to DCF under a multi-year, open-ended contract related to the state KidCare initiative. The contract permits the institute and DCF to define research projects as needed and it has also been amended to incorporate additional, related evaluation issues as they come up during the research process. It is not clear how the present arrangement will be affected when the current contract expires. Newly enacted state procurement laws and OPM policies may require CHDI to provide all future services on a project-by-project competitive basis.

Applying this policy to CHDI, a nonprofit, independent research institute that works in partnership with public and private academic institutions, appears counterproductive. The existing contractual arrangement permits the institute and the center to provide DCF with much-needed expertise to implement and monitor the effectiveness of evidence-based behavioral health service models. CHDI and CCEP can both consult with the department about best practices, provide technical assistance on developing service systems, and conduct research-based program evaluations.

Requiring DCF to use a separate RFP processes for every CHDI evaluation service would limit the responsiveness, timeliness and usefulness of the institute's work for the department. Child welfare agencies in several other states effectively use on-going partnerships with academic or other independent research institutions to increase their capacity for program evaluation, quality assurance, and system development. **Therefore, the committee recommends:**

DCF should be permitted to establish a long-term research partnership with the Child Health and Development Institute and its affiliate, the Connecticut Center for Effective Practice, through a multi-year, sole source contract to carry out a broadly defined research and evaluation agenda related to the agency's mission.

Another strength exists with the *establishment of the Behavioral Health Partnership (BHP) and the development of its Administrative Services Organization (ASO)*. The process to create the BHP was transparent and informed by the experience of all DCF stakeholders. It has fostered a strong cooperative relationship between DCF and DSS concerning behavioral health matters for children and families. The ASO now provides DCF with extensive data previously unavailable that can be and is used to assess the quality of behavioral health services and providers, determine if services are effective, and examine needs for new services.

Constituencies within and outside of DCF, however, have expressed concern over the ASO role to match children with appropriate services and placements, given the organization's limited case-specific information and minimal knowledge of children and their families. Since the ASO is in its first year of implementation, it is too soon to know the extent of problems of this nature. The BHPOC has authority to monitor this issue and it also should be addressed in the upcoming independent evaluation of the ASO being carried out for the council.

Another internal DCF monitoring and evaluation strength is the agency's ombudsman office. The function, which had been informal and scattered through the agency, was recently consolidated into one unit, with dedicated, professional staff, protocols for handling inquiries, and an information system to track calls. Ombudsman staff assigned as liaisons to all DCF facilities and offices meet regularly with agency staff and clients. With its clarified role and significantly expanded staffing, the DCF ombudsman has improved the agency's ability to receive and respond to external feedback from children and families, providers, and members of the public.

The committee further found many areas of quality improvement strengths have been developed throughout the department in response to the *Juan F.* exit plan. For example, the agency decentralized its operations to create smaller areas offices, each with a quality improvement manager and requirements for quality improvement teams responsible for developing and implementing local quality improvement plans. Also, the ROM system was developed to provide all managers and staff with performance measurement data.

The 105 staff of the department's continuous quality improvement bureau have been directed to focus on supporting efforts to achieve better results rather than meet compliance standards. The agency has also been working to develop research and analysis capacity, through the bureau's Risk Management and Decision Support Units which are intended to support results-based management practices throughout the agency. DCF also hired a full-time research scientist to provide advice and technical assistance on performance measurement and outcomes analysis.

As noted in the previous section, the Risk Management Unit supports the work of the department's Service Evaluation and Enhancement Committee by integrating certain performance data, particularly concerning private providers of residential services for review and development of needed corrective actions. The SEEC function is another monitoring strength in the agency. However, after reviewing three years of meeting minutes, the committee found the committee's response to incidents raised were not always handled in a timely manner.

In addition, there appeared to be inadequate attention to reviewing patterns to avert a crisis. For example, over a nearly three year period, critical incidents and significant events were noted repeatedly for one residential facility. In response, the committee assigned the facility to a review by the Program Review and Evaluation Unit. It was expected to be completed within three weeks; but instead the final review was not issued until a year and half later. Following the review, critical incidents concerning the facility continued to be reported to the agency's Hotline.

One factor contributing to the SEEC's inability to ensure a timely response to problem providers is the lack of resources for ongoing oversight and support of the entities under contract to the agency. Currently, program leads, who are agency staff with other full-time responsibilities, including bureau chiefs and program directors, have primary responsibility for provider support and technical assistance. They do not have the time to focus on building partnerships with the department contracted service providers.

In the past, the department had staff positions in its area offices assigned to oversee contracted providers. In addition to contract management, these staff could build and maintain positive relationships with the many facilities and community-based organizations that work for the department. These positions were eliminated under budget cuts made during the state fiscal crisis several years ago.

During interviews with provider groups and department staff, it was noted that several other agencies have developed effective ways to work in partnership with their providers. For example, in the past, DMHAS used a model where a team comprised of a fiscal staff person and a program staff person were assigned to work with each provider. While the program staff had the day to day connection with service operations, program, fiscal, and information system people would all meet regularly with providers. At these meetings, the staff from the three areas with provider responsibilities and the provider would talk about performance issues, problem solve, and make necessary decisions for corrective action.

The committee believes this approach of combining contract management, evaluation, technical assistance and support would improve the department's partnerships with its providers. **Therefore, the program review committee recommends:**

DCF should reexamine the role of its program lead position and consider the allocation of time necessary for this responsibility. DCF should also develop a team approach for working with contracted providers that will ensure contract obligations are being met, provide assistance when necessary so that programs do not reach a crisis point, and support and assist programs with quality improvement.

Deficiencies. A deficient area is the monitoring of contracted services. As noted by the Arizona Office of the Auditor General, "Contract monitoring helps protect funds and the clients being served by identifying and reducing fiscal or program risks as early as possible. Specifically, monitoring helps ensure that contractors comply with contract terms and conditions,

that performance expectations are achieved, and that any problems are identified and resolved in a timely manner.”²

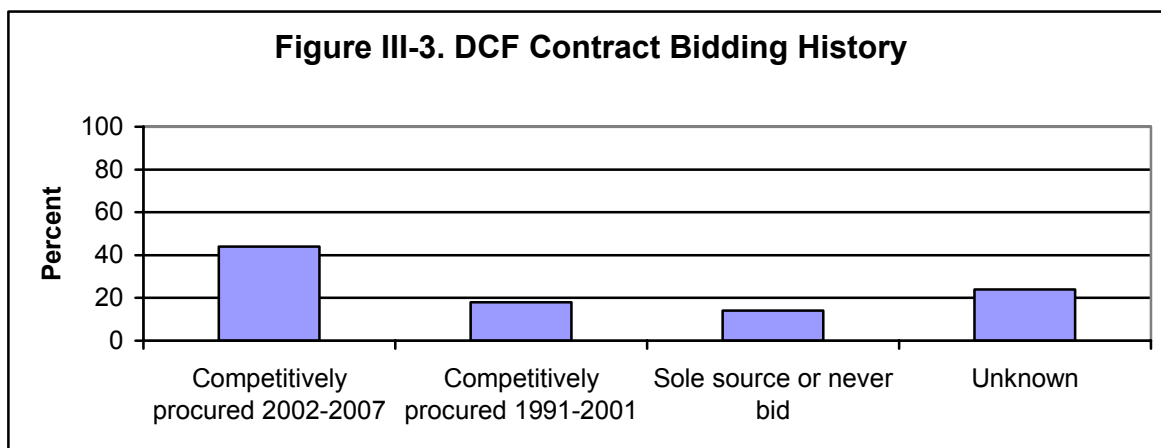
The report further cited four best practices in contractor monitoring identified by the National State Auditors Association.³ As shown in Table III-1, based on interviews and document examination, the committee found little if any evidence of use by DCF of contractor monitoring best practices.

Table III-1. Evidence of Use by DCF of Contractor Monitoring Best Practices	
Best Practice	Evidence of DCF Use of Best Practice
Uses qualified monitoring staff	DCF monitoring of providers and implementation of contract requirements is haphazard at best, often relying on the interest and time available of the program lead, ranging from conscientious to vacant position
Conducts periodic on-site reviews and observations	Visits were conducted twice a year in Arizona; however, DCF program leads are juggling multiple responsibilities and often do not have the necessary time nor a protocol to follow in making and processing such visits. DCF Licensing site visits occur once every two years for some programs, and are limited to regulations in their scope of examination
Addresses contractor performance deficiencies promptly	Best practices call for monitoring staff to immediately address deficiencies in contractor performance, including poor quality of service, failure to perform all or part of the contract, and chronically late report submissions. PRI staff found no evidence of this best practice in DCF contract monitoring
Verifies billing invoices	Best practice calls for monitoring staff to review all invoices for payments against contract terms and pricing. No payment should be made unless the work is satisfactory and in accordance with contract terms. The DCF Grants Development and Contracts Division appears to have the majority of staff dedicated to fiscal administration and monitoring of contracts; however, the committee found that provider payment occurred regardless of satisfaction with the service provided

² Performance Audit of the Department of Economic Security, Division of Children, Youth and Families—Prevention Programs, State of Arizona, Office of the Auditor General, July 27, 2007.

³ National State Auditors Association. *Contracting for Services: A National State Auditors Association Best Practice Document*. Lexington, KY: National State Auditors Association, 2003.

In examining the competitive bidding process, the committee also found that of 93 DCF services offered by contracted providers totaling \$193,078,587 annually, 18 percent had last gone out to bid in 2001 or earlier (see Figure III-3). The Grants Development and Contracts Division, which provided PRI with this information on when contracts had last gone out to bid, classified nearly one quarter (24 percent) as “unknown” (totaling \$13,584,800 annually).



The committee further found that in many instances the data requirements are vague and not specified in the contract. For example, the contract states that the provider will “submit required statistical, financial and programmatic reports necessary for establishing payment schedules and grant formulae, monitoring and evaluation and the establishment of MIS.” In other instances the required information is specified in the contract, may or may not be collected, and is often not analyzed due to concerns about the quality of the data.

While concerns regarding performance-based contracting are found throughout this chapter, an additional area for improvement is the relationship between the provider and DCF monitor charged with oversight of implementation of the service. Other state agencies, such as the Court Support Services Division, reportedly work very closely with their contractors, including sitting in on hiring interviews and helping to provide support if there are struggles or issues related to implementation of evidence-based models. DCF does not maintain a similar relationship with its providers. Such a partnership would be valuable in getting needed services to the children and families of DCF. **Therefore, the committee recommends:**

Considering contractor monitoring best practices, DCF should examine the roles of staff within the Grants Development and Contracts Division to determine whether some of the 19 positions could be reallocated from the financial/accounting function of contract management to program development and implementation support activities.

PRI staff, in gathering the information needed to assess the internal monitoring and evaluation efforts of DCF, also had some difficulty in locating contracts. While many of the contracts are stored in an electronic library database accessible on the DCF intranet, other contracts, such as PSAs are not online, nor are federal grants received by the department. The

current library does not maintain prior contracts online. The contract library could be made more complete by scanning in paper copies of any grants or contracts missing from the electronic library, and retaining previous year's contracts. **Therefore, the program review committee recommends:**

DCF should maintain a centralized and complete electronic grants and contracts library on the department's intranet. Grants and contracts missing should be scanned into the library. Previous year's contracts should be maintained for future reference.

Another deficiency is the lack of a formal process for soliciting feedback on the satisfaction with a provider prior to renewal of a contract. While it is certainly the case that there are limited options for particular services due to the paucity of providers, nevertheless, substandard service should not continue to be funded without some required improvements. In the past, there were DCF staff assigned to overseeing contracts in each of the regional offices. With the transition from five regional offices to 14 area offices, and other funding challenges, this effort was disbanded. Area office staff and program leads should be in a position to assess the services provided by a contractor and their input should be a pre-requisite to contract renewals. **Therefore, the committee recommends:**

The department should require the Grants Development and Contracts Division to receive and review feedback from area office and program lead staff on the performance of a provider before deciding to renew a contract. If concerns are raised about a provider, then discussions with the appropriate parties should occur and a performance improvement plan developed.

The committee became aware of deficiencies in the development of new services. There is confusion among providers regarding their ability to make suggestions to the department and subsequently bid on any future related requests for proposals. While contract administration must adhere to the highest standards possible, DCF, OPM, the AG's Office and others affected by this issue, should develop a process whereby programming suggestions from these experts is welcomed and providers are not penalized or subsequently barred from submitting a bid to provide the service. **Therefore, the program review committee recommends:**

A workgroup should be convened by the department and the Offices of Policy and Management and the Attorney General to clarify the guidelines regarding contract bidding and related programming suggestions.

Based on the principle of partnership, providers should receive a response from DCF to a formally submitted idea. PRI staff was told of instances when the department did not respond to a formal suggestion, or responded informally many months later. As a way to demonstrate the value that the department places on the providers, the department should publicize a clear format and process for providers to submit program ideas to the department. The ideas then deserve a careful review by the appropriate staff within DCF, and a formal response and any next steps conveyed to the provider submitting the suggestion. **Therefore, the committee recommends:**

DCF should develop a protocol for providers to submit suggested programs or program enhancements. A form for submitting the idea should be developed and timelines for response from DCF publicized.

Another deficiency is the lack of DCF staff with analytic abilities. Absent the capacity to analyze data collected as required by the performance-based contracts, the information cannot be used in any meaningful way. In general, department managers acknowledged a critical shortage of analytic staff in the department able to assume such responsibilities. PRI staff was told by management that one barrier is the limitation of the current DCF job classifications. Managers attempting to fill analytic positions rely on luck that they can find a social worker that would be capable of analytic work—however; there is concern that DCF is not able to develop the appropriate pool of applicants. **Therefore, the program review committee recommends:**

DCF should work with DAS to develop: 1) an appropriate job classification for staff positions within the agency responsible primarily for research and analysis; and 2) recruitment strategies for obtaining personnel with the necessary qualifications to fill them.

Furthermore, the department should increase its internal analytic capacity. The size and scope of the Risk Management Unit staff should be expanded to include the following duties in addition to compiling information to support the SEEC function: interpreting data produced by the ASO; compiling contracted evaluation results; maintaining the research repository recommended earlier; supporting agency strategic planning activities; and sharing outcome, best practices and result information agencywide.

Another deficiency found was that there is no systematic way whereby staff determines when to hire external evaluators to assess programs. Decisions are based on individuals within the agency and when they feel it is necessary regardless of the type of program or size of the program. **Therefore, the committee recommends:**

For programs exceeding \$20 million in funding, DCF should require an external evaluation be conducted to assess the outcomes of the program.

Another deficiency was found in relating the monitoring and evaluation recommendations to the findings of the study. In several instances, it was unclear what finding or result was being addressed by the recommendation. Additionally, action steps were developed to implement the recommendations; however, the recommendation being addressed by the action plan step was not necessarily understood. Third, the action was not always within the control of the receiving agency or department, making it difficult to influence accomplishment of the action. **Therefore, the program review committee recommends:**

DCF should develop and issue guidelines for staff and consultants regarding the format for final evaluation reports.

For example, report findings should be paired with the associated recommendation to assure that the recommendation is logically related to the finding. Also, recommendations should be numbered and any subsequent action plan should refer to the numbered recommendation (and recommendation itself) in any subsequent action plan. Additionally, when action plans are developed they should be within the control of the receiving agency or department.

Until recently, there appear to have been deficiencies in the monitoring and evaluation of licensing of foster parents. During the past year, the department has been researching best practices, and has revised its foster care structure and procedures. In June 2007, the Office of Foster Care Services issued a plan that in addition to recruitment and retention strategies outlines a series of new quality improvement activities. These include such efforts as implementation of a pre-disruption conference policy, enhancement of the PRIDE foster parent training curriculum, and development of a client level data set. Additionally, the Office of Foster Care Services plans to incorporate uniform performance indicators with specific employee performance standards, intensify efforts to partner with the community, and provide foster parents with mechanisms to provide feedback.

At present, foster parents undergo relicensure every two years. Every quarter, Foster and Adoption Support Unit social workers visit foster parents, assessing such areas as family composition, physical dwelling, sleeping arrangements, and updates on children. Visitation and treatment plans are discussed, as well as child-related concerns and any other issues.

Another area of potential deficiency concerns the department's internal process for handling child abuse and neglect reports filed against DCF employees. A conflict of interest arises whenever an agency is investigating itself. In addition, the committee became aware that DCF is not in compliance with a statutory reporting requirement concerning abuse and neglect reports for delinquent children (C.G.S. § 17a-103c). This statute requires DCF, upon the receipt of a report of suspected abuse or neglect of any child committed to the department as a delinquent, to notify the child's attorney in the delinquency proceeding. According to the Public Defenders no reports have been received since January 2007. Given the conflict of interest concerns and the department's noncompliance, **the program review committee recommends:**

The Office of the Child Advocate should undertake an investigation to assess adequacy and integrity of the internal process for reviewing and responding to allegations of staff child abuse and neglect. It should also and examine compliance with C.G.S. § 17a-103c.

Gaps. Considering DCF internal efforts only, there appears to be gaps in the internal monitoring and evaluation efforts in assessing outcomes, with almost two-thirds of all monitoring and evaluation efforts focusing solely on service delivery (process) rather than on outcomes, or end results. There also appear to be gaps in the internal monitoring and evaluation of the agency as a whole, with agencywide efforts accounting for just six percent of all internal efforts examined.

The strategic planning process recommended earlier is intended to get at this gap. The new planning process can also begin to address a related deficiency -- the lack of significant input from children and families, community groups and other external stakeholders in the

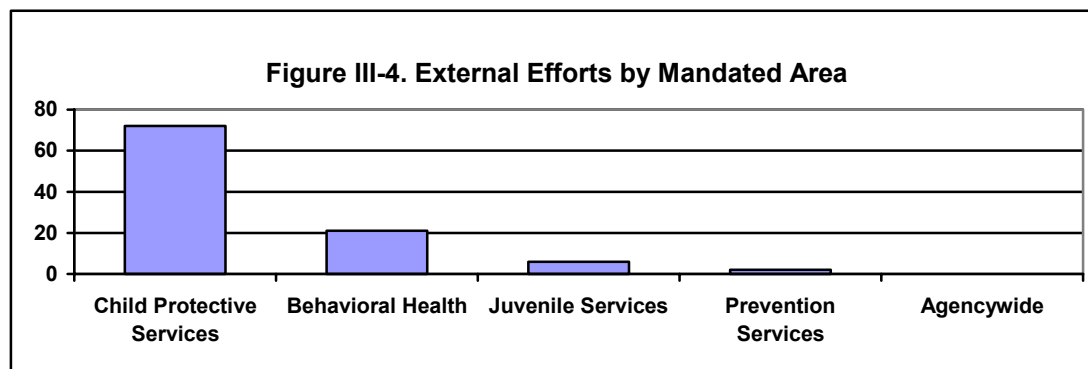
quality improvement process. This problem was noted by the *Juan F.* consent decree Technical Advisory Committee in 2002 report and remains an issue, according to staff interviews with a wide range of outside constituencies.

Redundancies. Considering the internal efforts only, there appear to be redundancies in the monitoring and evaluation efforts, particularly for the *performance-based contracts* within the behavioral health mandated area. For example, the same demographic information on the client will be required to be entered into two separate data bases in order to receive payment and satisfy the data submission requirements of the contract/ABH.

Another redundancy is in the *development and use of individual facility automated databases*, often in ACCESS, rather than use of an agencywide information system (See DCF Information System recommendation at the end of this section).

External Findings and Recommendations

Where external monitoring and evaluation occurs. Grouping programs into their mandated area, Figure III-4 provides a breakout of external monitoring and evaluation efforts by mandated area. *The greatest amount of external monitoring and evaluation efforts examined in this study are within child protective services (72 percent).* Approximately one fifth (21 percent) are within behavioral health services, 6 percent within juvenile services, and 2 percent within prevention services.

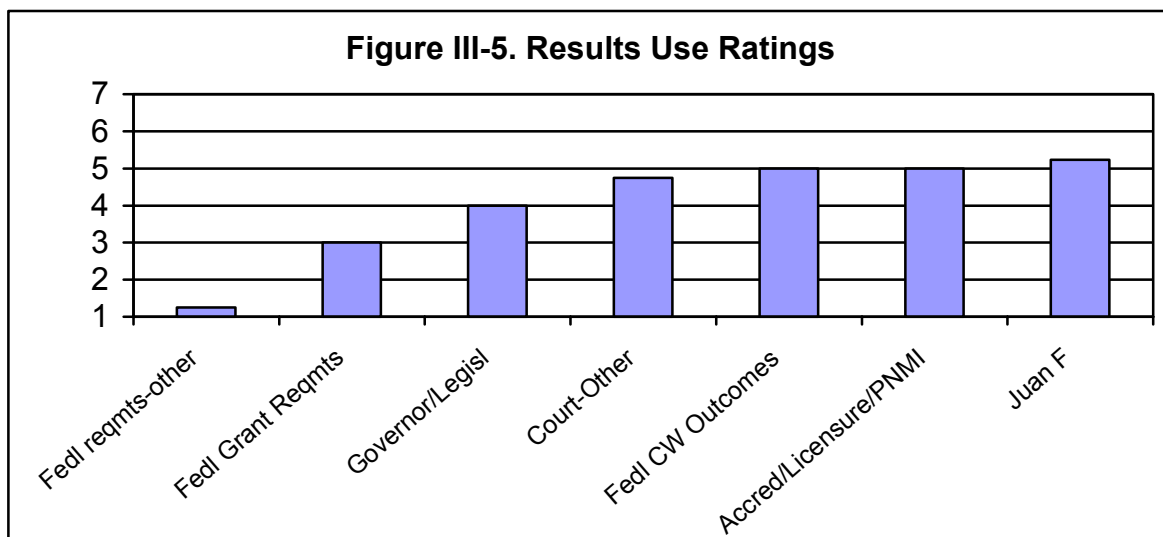


Goals and issues studied. Overall, the external goals and issues studied are stated in a way that lends them to being readily monitored and evaluated. One exception found by the committee was the relevancy of the DPH licensing of the Wilderness School. DPH does not have a category for wilderness schools and, therefore, licenses it as a camp. Since the DCF Wilderness School is not a camp, **the committee recommends:**

Wilderness School staff should work with the Department of Public Health to develop a more appropriate licensure as a wilderness school rather than as a camp.

Results use. Figure III-5 shows the external efforts that resulted in the greatest use of monitoring and evaluation results were: *Juan F.* outcome measures; accrediting body, external licensure, and PNMI/Medicaid; and federal child welfare outcomes. Other federal requirements (other) such as AFCARS, CFSR and Title IV-E Foster Care Eligibility Reviews, had results that

were least likely to be used to identify organizational or resource barriers, changes to policies, training, or services to children and families, or to seek legislative changes.



Results Based Accountability. The committee found the RBA process represents an effective mechanism for legislative monitoring and evaluation of DCF. It incorporates the best practices of continuous quality improvement: defined outcomes and standards; relevant data collection and analysis; and use of results to identify strengths and areas in need of improvement.

The principles and procedures of results-based accountability also closely correspond with the main quality improvement initiatives that are underway and being planned by the department. At this time, results based accountability is still a pilot project within the appropriations process. For the two uses of RBA by DCF, the committee found that a more comprehensive set of measures is needed. For example, the purpose of foster care is “to provide for the health, safety, permanency and development of children who cannot remain in the care of their birth parents.” Yet the three RBA measures of performance are limited to percentages regarding single foster care placements, completed multi-disciplinary examinations, and foster parents accessing training. The process, however, has the potential of providing legislators and the public with an objective, systematic, and comprehensive way to assess how well the department is achieving its goals.

Statutory reporting requirements. DCF is required by law to report on matters that cover all mandate areas of the agency as well as on agency-wide activities. Overall, there are more than a dozen different plans and reports the department must prepare and submit periodically to the legislature.

The committee found many of the required reports have either never been issued or were only issued immediately following the issuance of the statute. Additionally, many reports now are obsolete or replaced by more recent, similar information requirements. In addition, the legislature has rarely, if ever, taken steps to obtain missing plans or reports.

Therefore, the committee believes several could be eliminated without loss of accountability. In fact, reducing the number and clarifying their purposes could focus department attention on the most significant aspects of its performance and information related to results. Committee recommendations regarding each statute concerning DCF are summarized in the Table III-2. Overall, the committee proposes two statutory reports be replaced and 11 statutory reports found to be redundant and unnecessary be repealed. Specifically, **the program review committee recommends:**

The below statutory reports be replaced:

- **DCF biennial 5-yr master plan (C.G.S. § 17a-3);**
- **DCF annual report on CJTS (C.G.S. § 17a-6b and C.G.S. § 17a-6c);**

And the following statutory reports repealed:

- **CBHAC annual local systems of care status report (C.G.S. § 17a-4a(e));**
- **CBHAC biennial recommendations on behavioral health services (C.G.S. § 17a-4a(f));**
- **Quarterly Hospital reports to DCF on psychiatric care (C.G.S. § 17a-21);**
- **KidCare Community Collaborative annual self-evaluations (C.G.S. § 17a-22b);**
- **DCF/DSS 5-year independent longitudinal evaluation of KidCare (C.G.S. § 17a-22c(c));**
- **DCF monthly report to legislature on children in sub acute care in psychiatric or general hospitals who cannot be discharged (C.G.S. § 17a-91a);**
- **CPEC cost-benefit evaluation of juvenile offender programs (C.G.S. § 46b-121m);**
- **Licensed child care facilities annual reports (C.G.S. § 17a-145);**
- **DCF annual evaluation reports on Unified District #2 to the education commissioner (C.G.S. sec. 17a-37(d));**
- **DCF to conduct studies to evaluate effectiveness (C.G.S. § 17a-3(a)(6));**
and
- **Adoption Advisory Committee report at least annually (C.G.S. § 17a-116b(g)(3)).**

The committee recommends enhancing one of the statutory requirements with a more inclusive directive. Since CJTS is required to prepare an annual report which is then reviewed by its advisory group, **the program review committee recommends:**

All DCF facilities shall be required to produce an annual report for their respective advisory groups. The report shall contain at a minimum the following:

1. Aggregate profiles of the residents
2. Description and update on major initiatives
3. Key outcome indicators
4. Costs associated with operating the facility
5. Description of education programs and outcomes

CJTS' advisory group found the process of producing an annual report helpful to the members and the facility. It gives the members information from which to make recommendations both formally and informally to the facility. The committee feels the advisory group is an important component in this recommendation because if the legislature requests the information directly it may either not be produced, similar to other statutory requirements or may not be utilized by the legislature.

Table III-2. Committee Recommendations Regarding Statutory Reporting Requirements			
Mandate Area	Reporting Requirement	Status	Recommendation/Reason
AGENCY-WIDE	DCF biennial 5-yr master plan C.G.S. §17a-3 (PAs 79-165, 86-15)	2000 the last year; Now Exit Planning serves as their plan	Repeal and replace with earlier Recommendation for a mandated strategic plan.
BEHAVIORAL HEALTH	CBHAC annual local systems of care status report C.G.S. §17a-4a(e) (PA 00-188) – 2003 was the last report	2003 is the only report that was done.	Repeal; See later recommendation for combining CBHAC and the SAC.
	CBHAC biennial recommendations on behavioral health services C.G.S. §17a-4a(f) (PA 00-188)	2003 is the only report that was done.	Repeal; See later recommendation for combining CBHAC and the SAC.
	Quarterly Hospital reports to DCF on psychiatric care C.G.S. §17a-21	Produced monthly from August 1999 – July 2005. Now the ASO has taken over the responsibility.	Repeal; Reporting is now handled by the ASO reporting
	KidCare Community Collaborative annual self-evaluations C.G.S. §17a-22b (PA 00-2 June Sp Sess, PA 01-2 June Sp Sess)	Currently fulfilling through the BHP "report card."	Repeal; Reporting now done through the Behavioral Health "report card"
	DCF/DSS 5-year independent longitudinal evaluation of KidCare C.G.S. §17a-22c(c) (PA 05-280, replaced earlier provisions requiring status reports	Completed by CHDI.	Repeal. No longer necessary, evaluations were completed by CHDI as required.
	Behavioral Health Reporting: 1. BHPOC annual report 2. BHP external, independent evaluation 3. DSS/DCF annual BHP evaluation 4. DCF annual report on estimated costs savings due to BHP	Either completed or in progress.	Maintain

Table III-2. Committee Recommendations Regarding Statutory Reporting Requirements			
Mandate Area	Reporting Requirement	Status	Recommendation/Reason
	DCF monthly report to legislature on children in sub acute care in psychiatric or general hospitals who cannot be discharged C.G.S. §17a-91a (PA 99-279)	ASO is now handling this reporting requirement.	Repeal; Reporting is now handled by the ASO.
JUVENILE JUSTICE	DCF annual report on CJTS C.G.S. § 17a-6b and 17a-6c (PA 03-251, first annual report due Feb 4, 2004; PA 04-89, adjudicated youth first report due June 1, 2004)	All reports completed.	Replace with the above recommendation that will apply to all DCF run facilities.
	CPEC cost-benefit evaluation of juvenile offender programs C.G.S. § 46b-121m (PA 00-172)	Completed. One time review.	Repeal. Report was completed so it's no longer necessary.
PROTECTIVE SERVICES	DCF annual status report on all committed children and on central registry and permanency plan monitoring system C.G.S. §17a-91 (status report since 73; registry and monitoring system required by 17a-110 since 1999)	2001 was the last year the report was completed	Maintain
	DCF Kinship Navigator Program annual report to legislature C.G.S. § 17a-98	Beginning in 2008	Maintain First report will not be issued until 2008
	Licensed child care facilities annual reports C.G.S. § 17a-145	Information faxed to the facilities but it is already collected by the department through other means.	Repeal; Duplication of reporting. Information collected through licensing and contracts.
OTHER	DCF annual evaluation reports on Unified District #2 to the education commissioner C.G.S. § 17a-37(d)	DCF was unable to provide copies	Repeal; Intent met by Department of Education reporting requirements for all school districts.
	DCF to conduct studies to evaluate effectiveness C.G.S. § 17a-3(a)(6)	Done on an ad hoc basis	Repeal; See earlier Recommendation
	SAC issue any reports deemed necessary (optional) C.G.S. § 17a-14	None ever issued	Maintain
	Adoption Advisory Committee report at least annually C.G.S. § 17a-116b(g)(3) (PA 99-166)	2002 was the only year a report was produced	Repeal; See subsequent recommendation that repeals this inactive advisory group.

Strengths. The external efforts were found to have several areas of strength. The *Juan F.* court monitoring process was cited by multiple sources interviewed by PRI staff as a having a strong positive impact on department practice, management performance, and resources for children's services. In particular, the exit plan process instituted three years ago has been a major factor in the agency's significant progress toward compliance with the goals of the *Juan F.*

consent decree. From January 2004 through June 30, 2007, DCF has achieved compliance with 17 of the 22 exit plan outcome measures required for compliance. The exit plan process is also a main reason for the department's renewed focus on improving its performance on the two most critical outcomes: appropriate treatment planning and meeting needs of children and families.

The effectiveness of the exit plan process is attributed to several key elements. These include: having clear, measurable goals; the comprehensive, objective, and ongoing monitoring and evaluation activities carried out by the *Juan F.* court monitor's office, described in detail in the previous briefing report; and the extensive internal quality assurance system put in place by DCF to respond to the exit plan requirements.

The internal system encompasses two important components, also described in the briefing report. First, there are the department's BCQI quality improvement division's activities and the work of the central office exit plan unit aimed at collecting and analyzing results data and then developing corrective actions aimed at meeting the *Juan F.* outcome measures. Second, it includes: the area office quality improvement plans for meeting the *Juan F.* Outcome indicators; the area office teams responsible for developing and implementing them; and the quality improvement program supervisors in each area office that oversee these efforts.

For similar reasons, the *Emily J.* and *W.R.* court monitoring processes, which were discussed in the committee briefing report, also are strengths within the external monitoring and evaluation system for DCF. Many of the parties interviewed by committee staff also cited greatly improved coordination of children's mental health services across agencies, systems, and within communities, as a highly desirable side-benefit of the judicial oversight process from both of these cases.

In general, follow-up efforts related to federal class action lawsuits have proved an effective means of improving services through strong monitoring and evaluation. To a large extent, this is because feedback on results from court monitors must be used by DCF to achieve better outcomes for children and families. However, court monitoring is an expensive and time-consuming endeavor. Some have also noted that it may impede development of an agency's internal capacity for and commitment to continuous quality improvement. According to the *Juan F.* court monitor, a critical part of his role is to help DCF build its own capacity for quantitative and qualitative analysis and institute an agencywide culture of result-based management.

Another strength is *the monitoring and evaluation efforts required by the federal grants*. The department has secured several large, multi-year grants, primarily from the federal Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA). Up to 20 percent of SAMHSA grants, for example, are required to be allocated to program evaluation. The evaluations are conducted by external evaluators--often hired from local universities such as Yale University and the University of Connecticut--with strong backgrounds and experience in program evaluation. Additionally, in-depth SAMHSA site visits often occur in years 2 and 4 of the grant, with formal evaluations, feedback and required responses included in the process. The research and evaluation reports produced from these federal grants would be beneficial to current and future DCF efforts; however, their distribution is limited. **Therefore, the committee recommends:**

Research and evaluation reports produced through federal grant requirements should be included in the report repository recommended earlier concerning contracted evaluation reports and internally produced research products.

Additionally, because of the high quality of the research and evaluation conducted on these new programs, the research and evaluation reports produced from these federal grants should be useful to future decision making regarding continuance of the program once the funding has ended. Monitoring and evaluation is only as good as the information that is used in decision making. The results from the federal grants may not be considered by the decision makers at DCF when planning for upcoming programs and services. For example, the Hartford Youth Project began with federal SAMHSA funding. PRI staff were told that the program is viewed nationally as a model community-based, early intervention strategy that has been quite successful. The program should be strongly considered for full continuation beyond federal funding, and replicated in other parts of the state. **Therefore, the committee recommends:**

DCF should adopt a written policy requiring that formal results from research and evaluation reports produced from federal grants be reviewed and considered when agency managers make decisions concerning future funding and/or continuation of programs developed with federal grants.

Deficiencies. Considering the external efforts only, there appear to be deficiencies in the LINK data system, which is relied on heavily for federal outcomes and requirements. In comparison to other New England and comparable states, Connecticut lags in development of an accurate, reliable SACWIS system (i.e., LINK). A federal Child and Family Services Review (CFSR) site visit is scheduled for September 2008, and DCF must comply with federal requirements that are significantly deficient. Additionally, PRI staff were told several times by DCF managers that the federal reviews, such as the CFSR review, are anticipated to maintain the progress made as a result of the *Juan F.* consent decree once the exit plan has been satisfied.

Gaps. Considering the external efforts only, there appear to be gaps in the external monitoring and evaluation efforts expended for non-child protective services mandated areas. For example, 88 percent of mandated area efforts are for child protective services, and programs with two or more external monitoring and evaluation efforts are all within the child protective services mandated area (foster care, adoption, and hotline).

There also appear to be gaps in the external monitoring and evaluation efforts in assessing outcomes, with prevention services and behavioral health services focusing their efforts on processes of service delivery rather than outcomes, or end results.

There also appear to be gaps in the external monitoring and evaluation of the agency as a whole, with no agencywide external efforts.

Redundancies. Considering the external efforts only, there appear to be redundancies in *case reviews*. The review of children's records occurs as part of *Juan F.* court monitoring, court efforts, and federal child welfare outcomes. Treatment plans, for example, are examined for the

Juan F. Consent Decree and PNMI/Medicaid reimbursement, with requirements slightly different for the treatment plans.

As described in the briefing report, federal regulations require that independent case reviews occur every six months, assessing such areas as the appropriateness of placement, safety, permanence, and well-being. Specifically, their responsibilities include a review of treatment plans, examining such areas as the way in which treatment goals are defined, and determining who is responsible for implementing the treatment plan within a given time frame. Case reviews may occur more frequently when circumstances require a new treatment plan to be prepared.

Each administrative case review (ACR) currently takes approximately 1.5 hours. They are conducted in the area offices and mandatory participants include the administrative case reviewer, DCF social worker whose case is being reviewed and his/her supervisor. Any member of the Area Resource Group, a community consultant, support-staff worker, and/or community service provider who has participated in any aspect of the case in the seven months prior to the review are also required to participate in the ACR, as well as the adoption specialist as needed. Note that the parents of children without terminated parental rights, foster parents and foster children themselves, who are age 12 or older are also invited to the ACR.

In addition, the *Private Non-Medical Institution Initiative (PNMI)* calls for a treatment plan review. Program Review and Evaluation staff spends time in the field evaluating provider compliance with the department's Private Non-Medical Institution initiative, a reimbursement system required by the federal government, based on the regulation of treatment plans. The PNMI review is a paper review, examining such areas as whether the appropriate person signed the proper documents and whether an activity occurred within a given time frame. The Program Review and Evaluation Unit expanded these PNMI reviews to include qualitative areas. Program Review and Evaluation Unit staff also conducts site visits to residential and therapeutic group homes for PNMI compliance.

There are some differences in the treatment plan requirements for the two reviews. For example, the therapeutic group home providers must be in compliance with PNMI standards as well as DCF standards. There is currently a disconnect between the two requirements. Staff are currently working on this issue; it is important to get the discrepancy resolved to satisfy *Juan F.* outcome requirements as well as federal reimbursement—up to 25 percent—for therapeutic group homes. **Therefore, the committee recommends:**

DCF should convene a workgroup including program leads, a representative from the *Juan F.* court monitor's office, and DSS to develop a treatment plan and review process that satisfies both the internal DCF and PNMI federal requirements.

Further, concerns have been raised regarding the absence of parents and other important members of the team when the treatment planning conference is held. The treatment plans have been viewed as weak and a deterrent to complying with the *Juan F.* Consent Decree requirements. Connecticut law requires that the state develop a treatment plan for every child in its care, and that the plan be reviewed at least once every six months (C.G.S. § 17a-15). Another

state law requires the juvenile court to order “specific steps” for the parents to take in order to facilitate family reunification (C.G.S. § 46b-129).

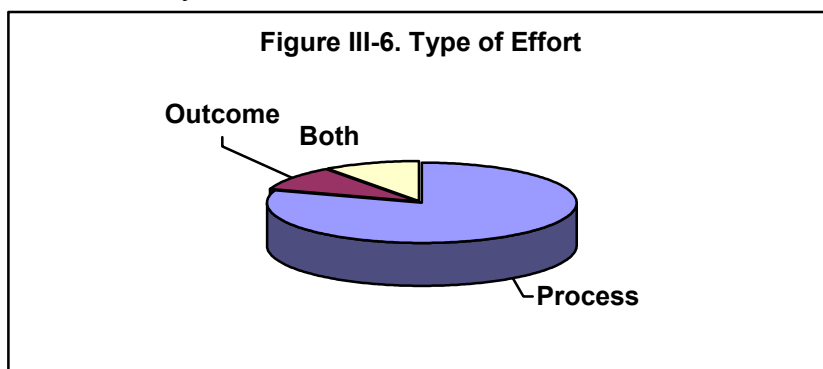
The specific steps are developed via a court-facilitated Case Status Conference, which usually occurs within eight weeks of filing of a court petition. At this conference, the key stakeholders discuss the issues that led to the state intervention and what services will be provided to assist the parent(s) in addressing issues and ultimately leading to reunification with their children.

The DCF treatment plan is developed separately and at approximately the same time as the court’s specific steps process. This may result in inconsistent plans and absence of important stakeholders in the process. Additionally, treatment plans may or may not be included in the court file and reviewed by attorneys. Some believe that integrating the court-ordered specific steps and the DCF treatment plan would strengthen the entire treatment planning process. The plan would be the result of discussion among parents (who are usually present at the court proceeding), children, DCF social workers, and attorneys. The fuller participation and development of a single, consistent treatment plan, would lead to a more comprehensive and higher quality plan (a deficiency cited in the *Juan F.* Consent Decree monitoring). A further advantage to this merging of the two treatment planning efforts is that it would ensure that implementation of the treatment plan occurs as they would be steps or actions that are court-ordered. **Therefore, the program review committee recommends:**

A pilot program should be created to assess the feasibility of conducting one treatment plan conference to be held at the court that combines: the Specific Steps identified during the initial case status conference at court and the corresponding DCF treatment plan conference currently held in the area office.

Investigative Findings and Recommendations

Process vs outcomes. More than three-quarters of all investigative monitoring and evaluation efforts focus solely on process goals or issues (80 percent of efforts), with progress on goal attainment limited to the delivery of service to the exclusion of outcome or impact (see Figure III-6). This finding is consistent with the expectation for facility investigations and child fatality reviews. Additionally, 10 percent contain both process and outcome goals or issues, and 10 percent focus solely on outcomes.



Goals and issues studied. The goals or issues that were the subject of outside investigative monitoring and evaluation efforts were found by the committee to be fairly specific, simple, concise, and clearly understood. Mixed ratings on how measurable the investigation goals or issues were based on concerns that the measures were not specified or sometimes open to interpretation (e.g., using the term “adequate”). Also, baseline data were missing.

Recommendations. Examining the recommendations from investigatory monitoring and evaluation efforts, the committee found that between 25 to 50 percent of the recommended changes were adopted per investigation/study effort. The fact that a majority of the improvements proposed in OCA and CFRP reports are not implemented by DCF does not seem to be related to their quality. The recommendations analyzed were found to be clear, logical and action-oriented. According to agency staff and Office of Child Advocate personnel, DCF have never disputed findings outlined in the OCA investigations and child fatality reviews and generally are in agreement about needed changes.

The monitoring and evaluation work of the Child Advocate and the child fatality review panel has contributed to improvements with significant impact, such as new policies and resources for domestic violence services in area offices, the adoption of better risk assessment and decision making procedures for child protective services cases, and dramatic reductions in the use of restraints for children in DCF facilities. The committee believes the department should be directing its attention to and making better use of the results of the investigative efforts of OCA and the Child Fatality Review Panel. **The program review committee recommends:**

The statutes concerning the Office of the Child Advocate and the Child Fatality Review Panel shall be amended to require the Department of Children and Families, and other state entities subject to OCA and CFRP investigative activities, to provide a written response to formal recommendations made by the child advocate and the panel for improving state services provided to children.

The agency response should include: proposed corrective actions to address identified problems; have a timeframe for implementation of improvements; and be provided to OCA or CFRP within 45 days of receipt of the recommendations. Copies of the agency response also should be submitted to the legislative committees of cognizance and the appropriations committee.

Strengths. The outside investigations and reviews carried out by OCA and CFRP strengthen the DCF monitoring and evaluation system in several key ways. Both entities provide an external perspective on how well the department is achieving its goals and are one of the few ongoing sources of agencywide performance evaluation. The child advocate and the child fatality review panel also have statutory responsibility and authority to look across state agencies and systems to identify problems and propose solutions in the meeting the needs of all children and families in Connecticut.

Another strength of the Child Advocate’s Office is its function as an independent place for parents, providers, and citizens to make known their concerns and complaints about public

services for children. OCA, through its use of on-site monitoring staff, also permits objective, external monitoring and evaluation of day-to-day operations at DCF facilities.

The child advocate, while serving as an independent source of assessment of state agency performance, has acted collaboratively with department staff and other external reviewers, such as the attorney general's "whistleblower" staff and the *Juan F.* court monitor's office. These efforts have addressed a potential for redundancy in areas of the child fatality reviews and in-depth evaluations of agency programs and facilities. Both OCA and CFRP have taken steps to avoid this by participating in the DCF/CWLA special review process, jointly conducting a recent facility review with the department quality improvement staff (e.g., the recent Riverview Hospital joint program review), and working with the agency's ombudsman office to resolve citizen complaints.

Gaps. Considering the investigative efforts only, there appear to be gaps in the monitoring and evaluation efforts in that more than three-quarters of all OCA monitoring and evaluation efforts focus solely on process goals or issues, excluding outcome or impact.

Deficiencies. There appear to be deficiencies in how measurable the OCA and CFRP goals or issues are because of vague measures and a lack of baseline data.

The effectiveness of outside investigative efforts also is impeded by resource deficiencies. The Office of the Child Advocate receives copies of all DCF critical incidents reports (estimated at about 8-10 per day); OCA staff review them to determine if further information or follow up is needed. OCA staff also process about 1,000 calls from the public per year. While some of the office's casework related to citizen calls has shifted to the DCF ombudsman office, a substantial number of cases still are opened for in-depth investigation by the child advocate and her staff. Based on its ombudsman activities, OCA opened between 170 to more than 360 cases per year during Fiscal Years 04 through 06.

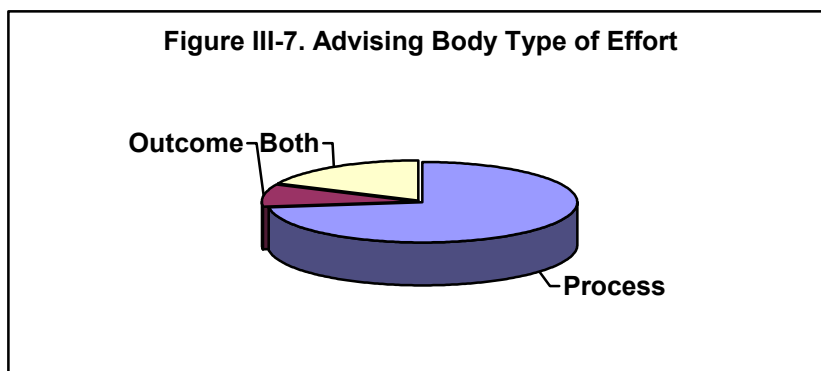
To handle this workload, OCA supplements its nine professional staff with interns and graduate students, especially to help with research projects and data analysis. In addition, the on-site monitor positions that OCA was authorized to hire to report on conditions at CJTS and Riverview Hospital following investigations at those facilities were funded through the DCF budget.

Limitations of its data management system, however, particularly for its ombudsman activities, continue to prevent ready analysis of trends, as well as tracking of responses to and the final resolution of cases based on citizen complaints. Estimates of the costs to upgrade the OCA automated information system are relatively modest (under \$200,000 plus annual maintenance costs of about \$12,000). However, as a small agency, the child advocate's office is a low priority customer of the state Department of Information Technology; it is not scheduled to receive services from that agency for a number of years. A small investment in new technology could greatly increase the effectiveness of OCA monitoring and evaluation efforts that already improve services for children and families. **Therefore, the program review committee recommends:**

The resources necessary to improve the OCA data management system should be provided during the next fiscal year, either by DOIT making this project a priority or through funding for a consultant to design and implement an upgraded system for the child advocate's office.

Advising Body Findings and Recommendations

Process vs outcomes. Figure III-7 shows that *almost three-quarters of all monitoring and evaluation efforts by advising bodies focus solely on process goals or issues* (73 percent of efforts), with progress on goal attainment limited to the delivery of service to the exclusion of outcome or impact. On the other hand, 18 percent contain both process and outcome goals or issues, and 9 percent focus solely on outcomes.



Issues studied. Overall, the advising body goals or study questions are not especially specific or measurable; however, they are considered realistic and within reach and the issue or question can readily be answered by monitoring and evaluation effort.

Information collected. In general, the information available for advising body monitoring and evaluation efforts is not of good quality with a fair amount of missing information. This is partly due to advising bodies' voluntary nature where they lack staff and resources and must instead rely on DCF or other sources for information.

Recommendations. Between 25 to 50 percent of the recommended changes were adopted per advising body. In interviews with various advising bodies, PRI staff was told that DCF did not always seriously consider their recommendations. The department's responsiveness should be improved through the following proposals for clarifying the roles of the advising bodies, as well as, promoting greater partnership.

Strengths. There are several strengths found in examining the DCF advising body efforts. **Area office advising bodies** appear to be effective when there is a strong partnership between DCF and the board. For example, both the Norwich Area Advisory Council and Bridgeport Area Advisory Council have a good working relationship with their respective area offices.

In Norwich, a partnership has developed where the council chairperson sits in on the office's monthly Quality Improvement Team meetings and a representative from the area office attends advisory council meetings. In Bridgeport, the Area Director attends the AAC meetings

and provides monthly statistics reports that provide a basis for feedback from the members. Both formats open up communication, give council members a better understanding what is occurring within the office, and enable them to find areas where they can assist local office and vice versa. These models provide a formal mechanism for receiving continuous feedback and information sharing allowing for a stronger partnership. **Therefore, the committee recommends:**

DCF should establish a policy for area office advising bodies to adopt a model whereby advising body members attend DCF area office quality improvement meetings, and DCF area office representatives attend advising body meetings, furthering promotion of a partnership.

A strength was also found with the CJTS advisory board. The board includes representatives from: community providers, the public defender's office, the mayor of Middletown, and juvenile court, among others.

At each meeting, CJTS staff present facility updates and distributes a summary report on critical incidents. The members of the board actively participate, offering suggestions on different ways to look at the data to understand trends, as well as other feedback on facility services and programs. Facility staff openly accept recommendations and appear to value the board input. In addition to this informal feedback, state statute requires the board to submit an annual report to the legislature, with clear guidelines for information it must contain. CJTS staff initially prepares the report, which is reviewed by the board. The board then develops recommendations that included in the submitted document.

Deficiencies. In many cases, *the statutory charges of the advisory bodies are weak in specificity and measurability.* The committee found that it was not always clear what DCF needed from the advising body, and goals and issues studied were not always specific. Thus, their achievement was unclear and information could be interpreted in several ways. Lack of clarity in purpose or charge may contribute to the low activity level for some of the advisory councils. The State Advisory Council and some Area Advisory Councils struggle to identify their function and purpose. Many groups want to help DCF improve its performance but are uncertain about the best way to accomplish that goal.

For example, Riverview Hospital's advisory board activity has ebbed and flowed in the past few years without clear direction from the facility or agency leadership. After many months of not meeting, the hospital's board was reinstated by the new acting superintendent in January 2007. Prior to her appointment, the advisory board lacked focus and was composed mostly of DCF employees. The board recently appointed a chair and is in the process of formalizing its structure and reaching out to expand the diversity of its membership. In the upcoming year, the advisory board plans to monitor progress with the facility's strategic plan and work on developing better relationships between Riverview Hospital and the community.

The Citizen Advisory board for High Meadows, initially established due to community concerns, has not met since January 2007. In the past it met quarterly and informally provided suggestions to facility staff. The Connecticut Children's Place advisory board also is inactive at present.

Currently it is at the discretion of the commissioner to establish facility advising bodies. However, similar to the nonprofit and private sector, all DCF run facilities should have an external advising body to turn to for advice and also to whom they are accountable. Because not all facility advisory bodies are as strong as CJTS' advisory body, yet members noted the beneficial nature of the advising body, **the program review committee recommends:**

DCF facility advisory boards be required by statute and mandate that all boards respond to their facility's annual report and that they add recommendations deemed necessary.

Further, the roles and expectations of these advising bodies shall be clarified by reflecting in statute their role as oversight entities for department facilities with responsibilities to assess outcomes and offer recommendations promoting programmatic or facility goals.

The committee also believes it is critical for DCF to have an effective external advising body composed of key stakeholders including parents, providers and community leaders that can examine agencywide issues, assess overall performance, and hold the agency accountable for results. The SAC should be a major consumer of the agency's quality improvement information, tracking trends, looking into needs, and examining outcomes within and across mandate areas.

To fulfill this role, it will need some dedicated resources; as a volunteer council of busy professionals and parents cannot be expected to provide meaningful oversight and advice without staff support. **Therefore, the program review committee recommends:**

The role of the State Advisory Council should be strengthened to include monitoring the agency's progress in achieving its goals as well as offering assistance and an outside perspective. The board's statute shall be written to clarify this role and DCF's participation with the board concerning strategic planning as recommended earlier in Section 1. The council's meetings should be held at locations that facilitate participation by members of the public, such as the Legislative Office Building, and its agendas and minutes should be posted on the DCF website. The department should provide the council with funding for administrative support services and to ensure members representing families from across the state can serve on the council.

The committee also found monitoring and evaluation efforts across the area office advising bodies that could be strengthened, and the potential for redundant efforts reduced, by a sharing of data collection strategies and ideas. To strengthen communication and sharing across the area office advisory bodies, as well as with the SAC, **the committee recommends:**

DCF should establish an electronic mechanism, for example a blog, where members of the area office advising bodies can share information with each other, the SAC and vice versa. Additionally, minutes and agendas from all meetings should be posted on the DCF website.

PRI found another deficiency in that only two of the department's three federally required **Citizen Review Panels** receive funding to fulfill their role. Under the federal Child Abuse Prevention and Treatment Act (CAPTA), Connecticut must establish a minimum of three Citizen Review Panels. Each panel must evaluate the extent to which the State is fulfilling its child protection responsibilities in accordance with its CAPTA plan.

This evaluation includes: 1) examining the policies, procedures and practices of state and local child protection agencies; and 2) reviewing specific cases, where appropriate. In addition, consistent with sections 106(c) (4) (a) (iii) of CAPTA, a panel may examine other criteria that it considers important to ensure the protection of children, including the extent to which the state and local CPS system is coordinated with the title IV-E foster care and adoption assistance programs of the Social Security Act. (Section 10(c) (4) (A) and (ii)). To assess the impact of current procedures and practices upon children and families in the community and fulfill the above requirements, citizen review panels must provide for public outreach and comment (section 106(c) (4) (C) of CAPTA). Finally, each panel must prepare an annual report that summarizes the activities of the panel and makes recommendations to improve the CPS system at the State and local levels, and submit it to the State and the public (section 106(c) (6) of CAPTA).

In 2005, DCF contracted with FAVOR, Inc., a statewide family advocacy organization for children's mental health, to administer two Citizen Review Panels. In 2006, the two panels were organized to review DCF protective services policies, procedures and other relevant material. Seven forums were held throughout the state to gather community feedback on DCF services and programs. In 2007, these Citizen Review Panels did not hold community forums but instead took a more focused approach.

The State Advisory Council assumes the role of the third federally required Citizen Review Panel. Like the other panels, SAC produces an annual report with findings and recommendations and the department then has six months to respond to it.

Currently FAVOR receives \$30,000 for the administration of its Citizen Review Panel while the SAC does not receive any funding for its panel activities. To enable all three federally required Citizen Review Panels to fulfill their mandate, **the program review committee recommends:**

DCF should fund all three required Citizen Review Panels equally.

Another deficiency is in the current structure and operation of the **Connecticut Behavioral Health Advisory Council (CBHAC)**. CBHAC, originally a subcommittee of the State Advisory Council that addressed systems of care issues, was formally established under P.A. 00-188 and now serves in an advisory capacity to the State Advisory Council. CBHAC has three statutory reporting requirements:

1. submit biannual "recommendations concerning the provision of behavioral health services for all children in the state" to the State Advisory Council;
2. review the Mental Health Block Grant and submit recommendations which accompany the state's grant application; and

3. submit an annual status report on local systems of care and practice standards.

CBHAC spent the past six months revising its bylaws in an attempt to provide more structure for its activities. The bylaws were approved at the September 2007 meeting. As part of the new bylaws, the behavioral health council now sends its monthly minutes, which can contain recommendations, to the SAC in an attempt to have more timely communication.

The committee noted the strong parent involvement in CBHAC required by state statute. In an effort to ensure this, reimbursements are provided to the families through family advocacy organizations. CHBAC, similar to other advising bodies, wants to help improve DCF; however its also struggles over the best way to accomplish that goal. In the past, members have felt there has been no response to their recommendations and it is unclear if they were ever received by the SAC. To strengthen the functioning of CBHAC and to ensure its input is given attention, **the committee recommends:**

Connecticut Behavioral Health Advisory Council should be incorporated into the State Advisory Council as opposed to remaining a separate entity.

Gaps. There appear to be gaps in the monitoring and evaluation efforts with several inactive or nonproductive advising bodies. The committee found two inactive groups whose purpose is currently being met by the department through other means.

The Adoption Advisory Council currently does not exist although it is written in statute. When initially established in 1999, the body was active and met quarterly. In 2002, the Adoption Advisory Council was merged with the Community Collaboratives. There are five collaboratives made up of members of the community and DCF that implement strategies for recruitment and support of foster and adoptive families. Each collaborative must do outreach to specific minority groups with recruitment efforts focusing on the need for placement for minority children. Strategies include: increasing visibility in targeted neighborhoods; organizing presentations and advertisements on minority radio; and targeting Latino cultural events. Additionally, each area office must develop a foster care recruitment plan with a focus on recruitment for minority and difficult to place children. Foster care and adoption recruitment should be a focus of both the SAC and Area Advisory Councils. Since the responsibilities have been assumed by the Community Collaboratives and the Multicultural Advisory Council, **the program review committee recommends:**

Repeal the statutory requirement for the Adoption Advisory Council (C.G.S. § 17a-116b).

Under state statute a public safety committee should be established to review safety and security issues that affect the host community where CJTS resides. Members must include the school superintendent and an unspecified number of representatives appointed by the mayor. This committee does not exist but its function has essentially been taken over by the CJTS advisory board, which includes as a member the mayor of Middletown. Because it is inactive and no longer necessary, **the committee recommends:**

Repeal the statutory requirement for the CJTS Public Safety Committee (C.G.S. § 17a-27f).

DCF Information Systems Findings and Recommendations

Currently DCF has multiple automated data systems that serve its different bureaus, programs, and facilities. Among the systems encountered during the course of this study are:

- LINK, the federal SACWIS system which serves the protective services population;
- ROM (Results Oriented Management), which pulls data from LINK and provides management reports on outcome measures with the capability to generate reports by office, unit and worker;
- A separate Access database which tracks adoption disruptions (not connected to LINK);
- The DCF facilities have Access databases storing information on the children served;
- Juvenile Services bureau has CONDOIT for their client population;
- Behavioral health providers submit data to the department through the Behavioral Health Data System (BHDS);
- Additionally, behavioral health providers must submit service utilization information to the ASO for the state BHP;
- Risk Management Access database tracking critical incidents;
- Significant Events Access database;
- Licensure has an Access database;
- ACT system for tracking Ombudsmen complaints; and
- Hotline utilizes ACD Navigator for entering and recording calls.

None of these systems are integrated nor can they communicate with each other. The above list is not comprehensive and does not capture other areas that could benefit from automation such as adoption and contract management.

The technology serving the department has been developed around services, not around the children and families in a consumer centric model. Technology can enable DCF to move toward a model that integrates the bureaus and the services offered in each. Similar to other states, Connecticut's SACWIS system was built by technicians, programmers, and case workers to meet federal child protective services reporting requirements and not necessarily to use the data in performing analysis or managing the continuum of care. The system was designed to support transactional reporting functions and report on the key federal outcome requirements. It does not, however, provide useable data to supervisors or the necessary analytic capability to improve outcomes.

Current Challenges. Table III-3 summarizes the challenges with the current LINK system.

Table III-3. Summary of Current LINK System Challenges	
Challenge	Description
Inflexibility	<p>If data entry errors occur the case worker cannot make changes even though it can have major implications for the entire case</p> <p>Currently DCF has a full time staff person dedicated to correcting LINK errors</p> <p>Due to the changing dynamics of child welfare practice, the system requires multiple enhancements; however making changes can require a tremendous amount of work</p>
Inaccurate reporting of placement of children	<p>If the legal status of a child is changed, the caseworker is not required to change the placement. Additionally, if the placement changes, the worker is not required to account for whether or not the child's legal status has changed.</p> <p>The system also does not include all placement arrangements, particularly non-paid placements; therefore, not all types of placements can be documented. For example, if a child ran away, the system does not force DCF to account for the run-away status. If a child is sent home but is still under DCF care, the placement field may not reflect this information</p>
Response time	<p>Due to the infrastructure required to support the technology, different area offices experience various degrees of performance with some noting performance is so prohibitively slow that it inhibits work productivity</p>
Userability	<p>DCF employees estimated it can take anywhere from 3 to 6 months for a caseworker to feel comfortable with LINK and that does not include additional time to train if a worker changes units from the investigations area to the foster care unit</p>

Table III-3. Summary of Current LINK System Challenges	
Challenge	Description
Obsolescence	LINK is currently 10 years old. There is the possibility that in the near future the vendor can no longer support the infrastructure or make it prohibitively expensive to make corrections. LINK relies on PowerBuilder technology, which has a very narrow market share. It has become increasingly difficult to locate technicians skilled in and willing to work on a PowerBuilder project on a cost-effective basis.
Non-compliance with Federal Requirements	The system is not federally compliant with 15 of 87 measures. Other states are experiencing similar problems, although many, including New York, New Jersey, Washington D.C. and Wisconsin, have decided to redesign their systems and move toward web-based technology.
Fragmentation	Users cannot access LINK to obtain all information about a child and his/her family (e.g. if the child has involvement with the juvenile justice system or Riverview Hospital).

An independent analysis is needed to determine the specific technological requirements necessary to integrate the department. Moving towards a web-based system allows for simple and easy navigation that mirrors how users currently navigate the internet. In addition, productivity improvements resulting from less administrative work due to ease and flexibility of the system are estimated to range between 20 and 30 percent.

Upgrading the current system to a web-based system would address the problems with varied performance reliability experienced by some of the area offices. Web-based technology would allow the servers to be located in closer approximation to the DOIT mainframe creating consistent performance for all the offices. Moving to a web-based system would also help with business continuity in the event of a disaster. Currently LINK must be loaded onto a computer in order to gain access to information, whereas with a web based system, caseworkers could access the system from any computer.

Federal SACWIS funding is available to move towards a web based system that supports the agencies service model. In addition, the federal government through the Centers for Medicare and Medicaid Services will support initiatives with an interoperability⁴ focus up to 90 percent, since many of the children are served by Medicaid.

Integrating all data systems would also assist the provider community. Currently providers send data to DCF but do not receive information back. Integrating data systems within

⁴ Means the process of effectively integrating services, technologies and support functions within and across departments to better serve families and meet the needs of an increasingly technology-focused work force.

the department and also creating a web-based interface would allow providers to enter data directly into DCF's system and receive information back instantaneously. DCF would also be able to integrate with the other agencies that serve many of the same children and their families such as the Judicial Branch, DMR, and DMHAS. **Therefore, the committee recommends:**

DCF shall hire an external consultant to:

- 1) Perform a gap analysis⁵ and workflow analysis with the focus on integrating the functions of the department with technology modeled to support the service model**
- 2) Develop the Project Plan**
- 3) Developing a RFP to procure the team needed to integrate the data systems and replace the SACWIS system.**

All of DCF's information systems, and in particular LINK, have required a large investment by the agency. However, given the status of their information systems it's time to look to the future to assess the needs for current demands on practice rather than pour more money into an antiquated and inefficient system. DCF serves the most vulnerable citizens where public officials need accurate information quickly. The mandate for DCF covers three major service systems, Child Welfare, Juvenile Justice and Behavioral Health yet the information systems don't support an integrated view of children and their families.

⁵ Identify technology requirements and assess what they currently have to determine where needs are not being met

Section IV

Findings From Monitoring and Evaluation Efforts

A major task for the committee staff was gathering findings on the performance of DCF services and programs. Study results and other available written materials from the various entities monitoring and evaluating the agency were reviewed. Although the department produces a number of reports containing activity and outcome data, this section brings together DCF agencywide and specific program performance information from internal, external, investigative, and advising body monitoring and evaluation sources.

The section begins with an overview of what is known about the progress made in achieving the department's main goals within the past three to five years. A detailed summary of consent decree data as well as federal evaluation results are then presented, two key monitoring and evaluation areas with considerable information. The committee then provides information about the effectiveness of programs within each of the four mandated areas and agencywide. The section concludes with a summary of key findings from monitoring and evaluation efforts.

As noted before, the information is not a complete inventory of agency results, as not every monitoring and evaluation effort occurring over the past three to five years could be reviewed within the study time frame. However, this information represents a large sample of DCF results data drawn from multiple sources and many types of outcome measurement and reporting activities.

Overview

One purpose of the PRI study was to determine what the various monitoring and evaluation reports produced within the past five years conclude about the performance of DCF. The committee found that *the monitoring and evaluation results are mixed, with some positive and some negative results*. Overall, the external monitors and evaluators are the most positive, and the investigators most negative.

In comparison to reports pertaining to one of the four mandated areas, those focusing on the entire agency were significantly more likely to have negative findings. The committee further found that investigations have the greatest proportion of efforts with an agencywide focus (40 percent), which also tend to have the most negative results.

Mandated area and agencywide results are shown in Table I-1. More detailed results are provided in the rest of this section.

Table IV-1. Selected Monitoring and Evaluation Data Results

Mandated Area	Data Results
Child Protective Services	<ul style="list-style-type: none">• Targets for the majority of quantitative <i>Juan F.</i> exit plan outcome measures concerning practice standards have been reached; performance is still considerably below benchmarks for quality indicators related to treatment planning and meeting children's needs• System gridlock (discharge delays, wait lists, lack of foster and adoption resources) exists in the current array of treatment and placement services• The number of foster homes is decreasing rather than increasing• The results are about the same for SAFE Home and Foster Care (e.g., similar average length of stay (seven months), sibling placement) but SAFE Home costs twice as much as foster care• From 2000-2005, the proportion of children put in family settings increased from 65% to 71% (found that the older the child, the less likely to be put in a family-like setting)
Behavioral Health Services	<ul style="list-style-type: none">• The Intensive In-home Care And Psychiatric Services program (IICAPS) found a decrease in the number of inpatient admissions and a decrease in inpatient lengths of stay for those who had to be admitted• The Hartford Youth Project found a decrease in alcohol use, marijuana use, illegal activity, and 5+ absences from school• Children impacted by the <i>Emily J.</i> settlement agreement were more likely to avoid residential placement (for 72 percent of children) and remain in the community for at least six months (for 2/3 of the children)• PARK project staff built a strong partnership with the school system in Bridgeport (viewed as "best practice")• The Mental Health Transformation State Incentive Grant (MHT-SIG) met 27 of 29 target goals (93 percent) including using Multi-Systemic Therapy, Multi-Dimensional Family Therapy, and other evidence-based treatment models to support youth with co-occurring disorders (both substance abuse and mental health disorders)

Juvenile Services	<ul style="list-style-type: none"> • Supervision of parole workers and parole supervisors was found to be inconsistent; there were no criteria or processes to guide parole decisions to discharge children from out-of-home care • The Connecticut Juvenile Training School (CJTS) showed the same or better ratings on 26 of 32 critical outcome measures over a recent six month period; two-thirds (64 percent) were the same or better than similar facilities in the field nationally • There has been a dramatic reduction in restraints and seclusion for boys at CJTS; however, there is not total compliance • The recidivism rate for 121 boys discharged from CJTS during Sept. 1, 2005 -April 10, 2006, was 35 percent (22 percent returned to CJTS and 13 percent went into adult criminal system) • CJTS discharge plans and aftercare are uneven • The purpose of CJTS activities is vague • A pilot program found a high percent of boys receiving needed services while at CJTS, and the majority follow up on post-CJTS needed services
Prevention Services	<ul style="list-style-type: none"> • Some program developers of evidence-based models understate the resources needed to implement the program with fidelity to the model; different contexts have unique sets of challenges; there are also issues with translated materials (Spanish not available or incorrect) • There has been an increase in self-confidence and self-reliance for youth who participate in a Wilderness School program
Agencywide	<ul style="list-style-type: none"> • Child fatality reviews found that DCF failed to monitor or follow up to ascertain whether parents were complying with court orders • Child fatality reviews found that DCF did not coordinate or facilitate communication between DCF, service providers, medical experts, court, attorney • Child fatality reviews found that DCF did not keep accurate records • Child fatality reviews found that DCF failed to follow its own policies
Source: LPR&IC	

Detailed Monitoring and Evaluation Results within Child Protective Services

Information about DCF's performance derived from the *Juan F.* Consent Decree and *Emily J.* Settlement Agreement court monitoring and federal evaluations is presented here. Data from monitoring efforts examined related to major child protective services programs, such as the Hotline, adoption services, foster care services, and SAFE Homes, are also discussed.

***Juan F.* Consent Decree.** Under the current exit plan for the *Juan F.* consent decree, sustained compliance -- defined as meeting performance goals for at least two consecutive quarters (a six-month period) -- with all 22 outcome measures is required before the court will

consider ending judicial oversight of DCF child welfare activities. In addition, total compliance must be maintained throughout the court's decision making process concerning termination.

Quarterly status reports prepared by the court monitor show steady progress is being made in achieving the exit plan goals. The latest report, issued on September 24, 2007, for the period April 1 to June 30, 2007, states the agency:

- is in compliance with 17 of the 22 required exit plan outcome measures;
- has sustained compliance with 15 measures for at least two consecutive quarters (6 months); and
- has not achieved compliance with five measures.

As detailed in the committee briefing report, the department has made considerable progress in achieving compliance with *Juan F.* consent decree outcome measures over the last three years. During the first quarter of exit plan compliance monitoring (January 1 through March 31, 2004), DCF met the standard for just one outcome. Since the first quarter of 2006, the department has met or exceeded compliance goals for at least 15 measures; in addition, targets for 15 measures have been maintained for at least one year, and for two or more years for 8 measures.

The court monitor's office released the results of its comprehensive case review, which includes findings from the targeted review of approximately 2,500 cases, in September 2007. Based on this review, the monitor found "... tremendous progress and improvement in fundamental areas of case practice..." over the past three years. Areas cited as showing "elevated" practice include: visitation contact; timely permanency outcomes for children; provision of multidisciplinary examinations for children; timeliness of investigations; increased emphasis on kinship resource searches; reduction in residential care placements, particularly those out of state; and improved educational and vocational outcomes for youth discharged after age 18.

While acknowledging the department's success in achieving a number of the exit plan goals related to compliance with timeframes and other process requirements, the monitor called for the department to focus attention on improving quality of effort, particularly in the area of treatment planning. Gradual progress in some areas of the treatment plan assessment was shown by the comprehensive case review. However, in spite of increased training and resources, plans were found to be developed without full participation of active case participants on a regular basis. In addition, treatment plans often lacked: clear, focused goals; inclusive action steps for the case participants, providers, and DCF; and identification of progress.

According to the monitor, a barrier to meeting the needs of children and families identified in their treatment plans is gridlock in the current array of available treatment services and placements options. Discharge delays are routine at all levels of residential behavioral health care and there are wait lists for community-based programs in most areas. Foster care and adoptive resources are also inadequate.

Summary of *Juan F.* Consent Decree results. To summarize, both parties and the monitor attribute the dramatic compliance progress since January 2004 to: a) the court monitor's efforts to track and report on results; and b) the agency's efforts, in response, to focus on corrective actions to improve performance. According to the monitor, due to capacity and treatment plan deficiencies, the pace of improvement has stalled over the last year as DCF remains challenged in meeting placement, permanency, and treatment needs for a number of children. Compliance for two closely related key outcomes -- Treatment Plans (#3) and Needs Met (#15) -- continues to be well below the targets established by the exit plan.

The court monitor's exit plan report for the second quarter of 2007 shows just 30.3 percent of DCF child welfare cases had appropriate treatment plans (versus the goal of at least 90 percent). Service needs of children and families were met in accordance with treatment plans in just over half (51.3 percent) of cases (compared with a target of at least 80 percent). The *Juan F.* Action Plan developed in the spring of 2007 to address the needs met and treatment planning goals is an attempt to replicate the success of the earlier Positive Outcomes for Children action plan for reaching other consent decree goals.

***Emily J.* Settlement.** Ensuring children involved in the juvenile justice system remain in the community is a key goal of the *Emily J.* settlement. Between October 31, 2005 and May 31, 2007, there were 335 children considered for diversion from residential placement. Of those, 243 (72.5 percent) were diverted to the community, 88 went to residential placement and 4 cases were still pending. Almost two thirds of the children diverted from residential placement (117) were DCF-involved.

Between October 31, 2005 and November 1, 2006, there were 96 children diverted to the community. As of May 1, 2007, a total of 65 (67.7 percent) of those 96 children remained in the community after their initial diversion, while 31 re-entered detention which resulted in residential placement.

Summary of *Emily J.* Settlement results. Collaboration between local DCF and CSSD personnel to put new services in place because of the *Emily J.* settlement has helped divert youths from the juvenile justice system, especially from residential facilities, to treatment in the community. In its second year, the settlement resulted in more than \$6 million in new community-based treatment services for detention-involved children at imminent risk for residential treatment. Together, both agencies have developed plans to sustain these programs and services and expand them statewide to constituents beyond the *Emily J.* class. As a result, 72.5 percent of children were diverted from residential placement. The *Emily J.* settlement was successfully completed and the case was closed in October 2007.

Federal evaluation results related to AFCARS. The Adoption and Foster Care Analysis and Reporting System (AFCARS) is a federally mandated system that contains case level information on every child in foster care for whom state child welfare agencies have responsibility for placement, care, or supervision, and every child who was adopted under the auspices of the state's public child welfare agency. AFCARS also has general requirements that check that the population that is being reported to AFCARS, and the technical requirements for constructing the data file, are correct.

In 2001, Connecticut's Adoption and Foster Care Analysis and Reporting System Assessment Review (AFCARS) report cited significant deficiencies on both population and technical general requirements. While none of the comparison states were fully compliant at the time of their AFCARS Assessment Review, there are also no comparison states to date that received such low scores in both requirement areas (see AFCARS assessment review description and results in Appendix P).

An AFCARS site visit occurred in January 2007, at DCF's request. A total of eight areas were reviewed during the 1.5 day site visit. Issues found related to removal dates, discharge dates, and treatment plans. Table IV-2 shows the general requirements and foster and adoption data elements that continue to be out of compliance. Since the first AFCARS site visit in July 2001, a total of 60 percent of the general requirements, 100 percent of the foster care data requirements, and 91 percent of the adoption data requirements that had been out of compliance in 2001, remain out of compliance in January 2007.

Summary of Federal AFCARS results. Connecticut continues to struggle to meet the federal AFCARS requirements. Two consultants were recently hired to work on AFCARS. They have developed an action plan that documents, for example, every element and lays out when coding changes for particular variables will occur, in priority order. Key improvements are needed in preparation for the September 2008 Child and Family Services Review, which will rely on AFCARS information.

Federal evaluation results related to Child Welfare National Outcome Standards. Connecticut had its Child and Family Services Review (CFSR) onsite visit during April 8-12, 2002, which examined records for the time period of April 1, 2001 through April 8, 2002. Table III-3 shows Connecticut's outcomes on these measures in relation to the national standards. Connecticut met national standards on two of the six measures (33 percent). The data reflected in Table IV-3 are prior to significant changes made by the department.

Other standards reviewed involve systemic areas, and Connecticut's conformance with the national systemic factors is shown in Table IV-4. The state achieved substantial conformity with four of the seven system factors (57 percent).

Table IV-2. AFCARS Areas Out of Compliance

Continued Non-Compliance Areas under *General Requirements*

- Three of the five general requirement areas continue to be out of compliance:
 - Capturing population of children that remain in the state's care, placement or supervision while the child has been on a trial home visit
 - Lack of previous removal information for cases that were open in 1993 or earlier, due to the department's conversion from a former system (CMS) to the LINK system
 - Lack of historical information related to removals and discharges for cases that were closed when the department converted from CMS to LINK, and have since re-opened

Continued Non-Compliance Areas under *Foster Care Requirements*

- All 34 Foster Care Data Elements continue to be out of compliance
- Progress was made on 22 of the Foster Care Data Elements
- Among the foster care requirements that continue to be out of compliance are:
 - Lacking dates of periodic reviews conducted on youth in the juvenile justice population that are under the care of DCF
 - Current placement setting does not capture runaways; are coded under "independent living"
 - Some Termination of Parental Rights dates were not converted from paper files to LINK

Continued Non-Compliance Areas under *Adoption Requirements*

- All 22 Adoption Data Elements continue to be out of compliance
- Progress was made on two of the Adoption Data Elements
- Among the adoption requirements that continue to be out of compliance are:
 - Setting missing information to "unable to determine" for whether child is of Hispanic origin
 - Defaults to "agency has determined the child has no special needs" when status has not been determined
 - Capturing of medical information such as visually/hearing impaired

Source: AFCARS Assessment Review Improvement Plan, Children's Bureau, March 2007

Table IV-3. Connecticut's Conformance with the National Standards in 2002

Data Indicator	National Standard (Percentage)	CT Percentage	Standard Met by CT?
<i>Repeat Maltreatment</i>	6.1 percent or less	11.4 percent	No
<i>Maltreatment of Children in Foster Care</i>	.57 percent or less	3.07 percent	No
<i>Foster Care Re-Entries</i>	8.6 percent or less	6 percent	Yes
<i>Length of Time To Achieve Reunification was less than 12 months from the time of the latest removal from home</i>	76.2 percent or more	55.1 percent	No
<i>Length of Time To Achieve Adoption was less than 24 months from time of the latest removal from home</i>	32 percent or more	6.5 percent	No
<i>Stability of Foster Care Placements (of all children in foster care less than 12 months, the percent that have had no more than two placement settings)</i>	86.7 percent or more	92.8 percent	Yes
Source: Children's Bureau Child and Family Services Reviews Key Findings Report, Connecticut Department of Children and Families			

Table IV-4. Connecticut's Conformance with the National Systemic Factors in 2002								
Systemic Factor	Achieved Substantial Conformity?							
	CT	ME	MA	NH	NJ	NY	RI	VT
Statewide Information System	No	Yes	Yes	Yes	Yes	No	Yes	Yes
Case Review System	No	No	No	No	No	No	No	Yes
Quality Assurance System	Yes	No	Yes	Yes	No	Yes	No	No
Training	Yes	Yes	Yes	Yes	No	Yes	No	Yes
Service Array	Yes	No	Yes	No	No	No	No	Yes
Agency Responsiveness to the Community	No	Yes	Yes	Yes	No	Yes	No	Yes
Foster and Adoptive Parent Licensing, Recruitment, and Retention	Yes	Yes	Yes	Yes	No	Yes	No	No
Source: Children's Bureau Child and Family Services Reviews Key Findings Reports Fiscal Years 2001 through 2004.								

Summary of Federal Child Welfare Outcome results. Connecticut was able to meet two of the six national outcome standards: foster care re-entries and stability of foster care placements. The federal report also examined seven national systemic factors, and cited several strengths of DCF's quality assurance system. These include the implementation of standards to ensure that children in foster care are provided with quality services, and the state's system capacity to monitor the quality of services, identify strengths and needs of the service delivery system, provide reports, and evaluate program improvement measures. The federal report also cited several concerns about the statewide information system, including an inability to determine the status, demographics, location, and goals for all children in foster care. The report also noted reviewer concerns with children in foster care not having written case plans, and children and parents not consistently involved in case planning when it does occur.

A Program Improvement Plan was developed by DCF and submitted to the Children's Bureau. In Fall 2003 the PIP plan was rejected by the federal government for lack of evaluative strategies. In recognition of a need for better use of data, the following year, Connecticut partnered with University of Kansas to develop a system to extract data from LINK, called the ROM reporting system.

Title IV-E Foster Care Eligibility Review. In state FY 07, Connecticut received \$106 million for reimbursement for foster care and adoption expenses under Title IV-E of the Social Security Act. As part of the monitoring to determine whether eligibility determination for reimbursement is conducted properly, state strengths and areas in need of improvement are

identified by the federal reviewers. In the most recent Title IV-E Foster Care Eligibility Review, it was noted under “strengths” that: “Overall, DCF and the Courts have significantly improved the content and timeliness of the court order sanctioning the removal of the child from his/her home.” Under “Areas in Need of Improvement,” the review reported that “six cases had issues with the lack of and/or untimely criminal records/safety checks.”

Table IV-5 shows the outcomes of the two most recent Title IV-E Foster Care Eligibility Reviews for Connecticut and other states in New England and the Northeast.

Table IV-5. Title IV-E Foster Care Eligibility Review Outcomes		
State/Region	Most Recent Review Substantial Compliance?	Next Most Recent Review Substantial Compliance?
Connecticut	Yes	Yes
Maine	Yes	No
Massachusetts	Yes	No
New Hampshire	Yes	Yes
New Jersey	No	No
New York	Yes	No
Rhode Island	Yes	Yes
Vermont	Yes	No
Source: Source: Children’s Bureau Website – Title IV-E State Reports (http://www.acf.hhs.gov/programs/cb/cwmonitoring/final/primary/ma.htm)		

Summary of Title IV-E Foster Care Eligibility Review results. In comparison to the other states, Connecticut is one of the few with substantial compliance for both reviews. The state was noted to have significantly improved the content and timeliness of the court order sanctioning the removal of the child from his/her home, while needing improvement in criminal records/safety checks.

Child Protective Services Program-Specific Results

Hotline. *The goal of Hotline is to: provide professional, timely response to reports of alleged child abuse/neglect and services to ensure the best protection of children.*

Hotline services have improved greatly in the past two years with regard to timeliness of commencement and completion of investigations. A new process called Structured Decision

Making, which is expected to improve substantially the agency's risk assessment process, was implemented in the spring of 2007. Regular evaluation of its impact on child safety outcomes is planned by a workgroup of agency staff and stakeholder representatives.

Adoption Services. *The goal of Adoption Services is to: provide permanent homes for children who cannot return to their biological families.*

Connecticut was far behind most other states in having adoptions occur within 24 months of a child's entry into care. The department has made great progress, however, in improving the timeliness of adoptions. DCF has sporadically achieved the related *Juan F.* adoption outcome measure, which is the same as the federal outcome measure. A negative consequence to improving the speed with which adoptions occur is the unacceptably high disruption rate found by the Court Monitor, and the record of DCF social worker concerns about the fit of the child with the family found by Casey Family Services.

Foster Care Services. *The goal of Foster Care Services is to: provide for a child's needs in a substitute family experience until return to home is possible, or, if not, until an alternate permanent home can be found.*

The shortage of foster homes makes it difficult for some children requiring out of home placement to have the need for a substitute family to be met. Despite this shortage, an increasing proportion of children in out of home care have been placed in foster homes (from 65 percent to 71 percent during 2000 to 2005). A federal review noted that Connecticut's courts and DCF have significantly improved the process and timeliness of necessary child removals, and can continue to improve in the timeliness of criminal record and safety checks of prospective foster parents. Relative foster care results in fewer placements compared with children in non-relative foster care. The department just completed a new plan for foster family recruitment and retention.

SAFE Homes Program. *The goal of SAFE Homes is to: provide better long-term outcomes in reunification and permanency, reducing the number of placements within the first year of care, insuring that more siblings will be placed together, and attempting to allow more children to remain in their communities.*

Similar outcomes occurred for children in both SAFE Homes and foster care in that there was a reduction for both in the frequency of placements and a similar length of stay in out of home placement. There was also a similar rate of reunification. Though no more effective than foster care in reunification and reducing the number of placements, SAFE Homes cost twice as much. The department is in the process of redesigning the SAFE Homes model.

Table IV-6 provides specific results from the 55 monitoring and evaluation efforts reviewed within child protective services.

Table IV-6. Specific Results for Major Programs Within Child Protective Services

For DCF Hotline:

- At least 90 percent of all reports commenced the same calendar day, 24 hours or 27 hours depending on response time designation. Hotline has been about to exceed this Juan F. exit outcome measure since 4Q04, with the lowest level of compliance in 4Q04 at 91.2 percent.
- At least 85 percent of all reports had their investigation completed within 45 calendar days of acceptance by Hotline. The Hotline department has maintained above 85 percent for the last 10 quarters (since 4Q04) for the Juan F. exit outcome measure, with the most recent quarter (1Q07) at 93 percent.
- These findings contrast with a 2003 hotline investigation by the Child Advocate and Attorney General where they found that DCF was not following policies and procedures, resulting in a failure to respond to child abuse properly and in a timely manner. They also found instances of cases with substantiated allegations of child abuse/neglect that were closed and families referred to another agency, but no follow up ever occurred.

For Adoption Services:

- In comparison to other states, Connecticut has the third lowest percent of adoptions finalized within 24 months of a child's entry into foster care; however, from 2000 to 2003, Connecticut had the greatest improvement of any state, going from 6.5 percent to 12.9 percent, nearly a 100 percent improvement.
- Looking at the *Juan F.* Exit Outcome Measure on adoption, a peak was reached in 1Q06 with 40.8% achieving adoption within 24 months of removal from his/her home; however, it declined for 2 quarters to 27% (3Q06) to below the goal. For the previous two quarters, it went up and in 1Q07, it was 34.5%. The department is unable to consistently sustain these adoption efforts; however, according to the Office of the Court Monitor, the small numbers (of children adopted) impact the outcome measure results.
- A study completed by the Office of the Court Monitor found that the overall time frame for adoption to occur remains too long with more than 25 percent of the children waiting four years or more. They also found the number of adoption disruptions is unacceptably high (9.1 percent) and suggested that additional or more effective adoptive parent support services, for a longer period of time, are necessary to ensure that adoptions are permanent.
- A study by Casey Family Services found that too much time is consumed making the decision as to whether to seek termination of parental rights, and concurrent planning is more of a concept than reality. They also cited a practice of further delaying the adoption finalization process of children who have passed the 24-month benchmark in favor of processing those who have not. In many of the disruptions, it was noted in the record that the DCF social worker had concerns about the fit of the child with the family but adoptions proceeded without services.

For Foster Care Program:

- Foster parents are visited at least once every three months by a DCF social worker from the Foster and Adoptive Services Unit; this unit is also responsible for licensing and biennial re-licensing of foster parents.
- Despite many efforts to recruit and retain foster families, the number of foster homes is decreasing rather than increasing, failing to meet the department's goal of 25 new homes (net) per month. In September 2007, for example, the department licensed 9 new homes, but lost 11 homes.
- The decrease in foster homes is due in part to the increased emphasis on adoption, draining the supply of foster homes as they adopt their foster children
- Half of foster parents leave within the first two years--many because they have adopted a child--however, there are a significant number who leave who are dissatisfied with DCF support (e.g., lack of information received about kids, not being included in decision-making, and child reimbursement levels and procedures)
- There is a particular shortage of foster homes for DCF's largest populations in care (0-5, 12-18 years old).
- In a Connecticut Association of Foster and Adoptive Parents Program (CAFAP) study of public perception of foster parenting, those with exposure to the foster care system were twice as likely to consider fostering a child (26 percent vs. 14 percent)
- A Chapin Hall Report on performance of the DCF foster care system found that, from 2000-2005, the proportion of children in out of home care that were placed in family settings increased from 65% to 71% (also found that the older the child, the less likely to be put in a family-like setting).
- Chapin Hall also found that just 14 percent of children placed with relatives experience one or more placement moves in the first six months in comparison to children in non-relative foster homes (47%).

For SAFE Homes Program:

- Though no more effective than foster care in reunification and reducing the number of placements, SAFE Homes cost twice as much.
- Following the establishment of SAFE Homes, the percent of school-age children with three or more placements in their first year of out of home placement decreased from 75 percent to 20-25 percent (was a similar drop for foster children).
- By one year follow up, half of children in SAFE Homes had returned home.
- The SAFE Homes Program Evaluation conducted by DCF and the Yale University Department of Psychiatry also found that the trauma history was much more severe than anticipated, and most experienced multiple trauma; 80% of birth parents had substance abuse problems.

Source: LPR&IC

Detailed Monitoring and Evaluation Results within Behavioral Health Services

This section provides information about the results from monitoring and evaluation efforts related to Riverview Hospital, Extended Day Treatment, Residential Treatment,

Therapeutic Group Homes, KidCare, and Outpatient Psychiatric Clinics for Children. Behavioral Health Evidence-Based Models and Behavioral Health Federally Funded Grant Programs results are also described.

Riverview Hospital. *The goal of Riverview Hospital is to: provide comprehensive, family-centered treatment of children and youth with serious mental illness and related behavioral and emotional problems who cannot be safely assessed or treated in a less restrictive setting.*

Riverview Hospital is faced with significant challenges that hamper its ability to provide comprehensive, family-centered treatment. The presence of an on-site OCA monitor, and implementation of a strategic plan with the hands-on support of the Director of Planning and Program Development, appear to be contributing to recent progress in addressing the facility's problem areas. There have been improvements in the work environment and improved functioning in some hospital operations.

Extended Day Treatment Program. *The goal of the Extended Day Treatment Program is to: reduce problem behaviors, promote competence, and prevent placements in more restrictive clinical environments, such as residential treatment or inpatient hospitalization (and ease the transition of children leaving a higher level of care).*

Extended Day Treatment obtained information from parents and guardians who report that the program has helped improve their children's functioning. More quantifiable measures of the efficacy of the program, such as percent of children who do not go to a more restrictive clinical environment, however, are not available due to data quality issues. The current program lead has taken steps to improve both the quality of the data as well as service delivery. It is anticipated that reduction of problem behaviors and an increase in child competence will be enhanced through adoption of the proposed family-focused model.

Residential Treatment Program. *The goal of the Residential Treatment Program is to: provide structured out-of-home treatment for children whose behavioral health needs are too acute to address in the community.*

Residential Treatment obtained information from contractors that has been analyzed to depict changes in functioning and placement following discharge. Improvements in functioning are seen for one-third of the children and deterioration for one-fifth of the children. Because there are no targets set regarding what percent are expected to show improvements in functioning, or what percent are expected to discharge to a less restrictive environment, this performance cannot be assessed.

Therapeutic Group Homes. *The goal of the Therapeutic Group Homes is to: provide a setting for youngsters for whom a family resource is not readily available, that has clinical, educational, recreational, and vocational services within the community to address the medically necessary goals for achieving relational support with caretakers and others in the community, and that provides children with assistance in improving relationships at school, work and/or community settings.*

Therapeutic Group Homes are in the process of being opened in communities across the state. An RFP has been issued to hire a program evaluator to examine the success of the Risking Connections Model and outcomes of the program. The focus of the program lead is currently on establishing new group homes. To date, there is no information on the efficacy of the homes. Monitoring and evaluation is limited in scope to the licensing regulations and PNMI/Medicaid requirements.

KidCare. *The goal of KidCare is to: enhance and develop comprehensive, coordinated, community-based mental health services to ensure children have access to appropriate services and receive them in the least restrictive environment possible, and avoid unnecessary out-of-home residential care.*

KidCare appears successful in avoiding out-of-home residential or inpatient care for 91 percent of the children and families served by the Emergency Mobile Psychiatric Services. Slightly more than half receive an array of intensive services, including wraparound services, and care coordinators are considered quite successful in securing needed services for children. A sizeable number of caregivers, however, are dissatisfied with certain services such as substance abuse treatment, extended day treatment, in-home services, residential care, and Emergency Department visits, the latter perhaps due to the weak memoranda of understanding between KidCare and the local Emergency Departments.

Outpatient Psychiatric Clinics for Children. *The goal of Outpatient Psychiatric Clinics for Children (Child Guidance Clinics) is to: promote mental health and improve functioning in children, youth and families, and to decrease the prevalence and incidence of mental illness, emotional disturbance, and social dysfunction.*

It is unknown the degree to which Outpatient Psychiatric Clinics for Children have improved functioning in children, youth and families, and decreased the prevalence and incidence of behavioral health problems. Steps are being taken to improve the quality of data submissions by the clinics. A trauma focused evidence-based model is being introduced that appears promising.

Behavioral Health Evidence-Based Models. *The goals of Behavioral Health Evidence-Based Models are: through implementation of the model, beneficiaries (depending on the model) will have reductions in the need for institutionalization (In-Home Child and Adolescent Psychiatric Services (IICAPS)), reduction or abstinence in substance use, improvement in school functioning, decrease in delinquent behavior and improvement in general family functioning (Multi-Dimensional Family Therapy (MDFT)), or to address the needs of adolescent juvenile offenders with serious behavioral problems (Multi-Systemic Therapy (MST)).*

The evidence-based model MDFT shows promising results in reduction or abstinence in substance use and a decrease in delinquent behavior. The IICAPS evidence-based model also shows promise in reducing the need for institutionalization and improving behavioral health problems. There is an absence of summary information on the overall efficacy of MST.

Behavioral Health Federally Funded Grant Programs. *The goals of Behavioral Health Federally Funded Grant Programs are: through implementation of the grants programs,*

beneficiaries (depending on the program) will have stronger community-based (Hartford Youth Project) and coordinated statewide substance abuse treatment services (Adolescent Substance Abuse Treatment Coordination), transformed mental health service delivery for young children (Building Blocks), and services through a school-based system of care that is more inclusive of children with serious behavioral health needs (PARK).

The federally funded projects have led to positive substance abuse treatment outcomes, and partnerships with school systems in addressing the behavioral health needs of youngsters. There are collaboration and partnership challenges in developing the coordinated systemwide system of substance abuse treatment, and in hiring the staff for mental health service delivery for young children.

Table IV-7 provides specific results from the 37 monitoring and evaluation efforts reviewed within behavioral health services.

Table IV-7. Specific Results for Major Programs Within Behavioral Health Services
For Riverview Hospital:
<ul style="list-style-type: none"> • In a DCF child fatality review, it was found that bureaucratic obstacles compromised efforts by hospital staff to collaborate with colleagues in other systems; medication management and interventions and discharge and aftercare were weak. • In a Joint Commission accreditation site visit in October 2006, there were just four areas that had recommended improvements, one of which required a response/corrective action ("pain is assessed in all patients"); all the other standards were met. • A joint program review conducted in 2006 by the BCQI, Office of the Ombudsman, and OCA found that, while the department had taken steps to enhance the services of the hospital and to meet the needs of the children, the hospital continues to have difficulties effectively meeting the needs of the children it serves. • The joint program review found unevenness in the effectiveness of service delivery. Some units use a coordinated team model with a philosophy of care that is child focused and child sensitive, while the majority of units were more rigid, focusing on behavioral control approaches with more punitive interventions. • The OCA Riverview Hospital Monitor noted that there is a strategic plan implementation group, and changes in executive management appear to have had a positive impact on the work environment—there is a lot less staff turmoil. • The OCA Riverview Hospital Monitor has concerns about staff following MD orders, defining seclusion, use of restraints and seclusion, and transition planning.

For Extended Day Treatment:

- Most parents and guardians surveyed by the program lead were satisfied with EDT services, and agreed that EDT helped improve their child's functioning.
- Concerns were raised regarding the lack of, limited, or ineffective clinical services, most notably family therapy, home-based family work, and crisis intervention services. There is a need to adopt a more comprehensive, family-focused philosophy and practice approach, with families having a more central role.
- The development of a model of care, in partnership with stakeholders, is currently under way to restructure and strengthen the EDT program through the adoption of a comprehensive family-focused philosophy and practice approach that places families at the core of all aspects of service delivery.
- Extended Day Treatment programs are licensed and as such, must adhere to regulations as verified through site visits.
- The current program lead for Extended Day Treatment has taken steps to improve the poor quality of the data currently submitted monthly and aggregated quarterly, make site visits to assess the quality of service (and require corrective actions as needed), and solicit stakeholder perspectives on Extended Day Treatment.
- Although required by performance-based contracting, DCF is unable to currently produce reliable results for outcome measures such as prevention of placement in more restrictive environments.

For Residential Treatment:

- Aggregated results provided by residential treatment contractors found two-thirds of discharged children had a successful course of treatment as rated by the providers.
- Children who entered residential treatment from an out of home placement were more likely to be discharged to a parent or relative (41.2% of discharges had entered care from the care of a parent or relative, and 48.3% were discharged to a parent/relative).
- Almost one-third (30%) showed an improvement in functioning (10+ point improvement in functioning on Global Assessment of Functioning scores).
- Almost one in five (18.8 %) was discharged to a more restrictive setting.

For Therapeutic Group Homes:

- 46 homes have been opened as of October 2007.
- There are 8 more to be opened; it is getting much harder to open homes due to community resistance.
- The homes have been instructed to use a service delivery model called, "Risking Connections Model."
- Oversight of the therapeutic group homes is provided by the Licensing Unit, program lead, and PNMI/Medicaid site visits/reviews conducted by the Program Review and Evaluation Unit.

For KidCare:

- A CHDI study of family satisfaction found general satisfaction with services for at least half of the caregivers surveyed; however, a significant minority expressed dissatisfaction with services their children received.
- The services that generated the greatest dissatisfaction from caregivers who said the service was not helpful for their children were: substance abuse treatment, extended day treatment, in-home services, residential care, and Emergency Department visits.
- The MOUs with local Emergency Departments are weak.
- Many of the children served by KidCare received an array of intensive services, with slightly more than half receiving some type of wraparound services.
- Emergency Mobile Psychiatric Services provided intervention for approximately 1,218 families per quarter with just nine percent requiring inpatient or residential care; one-quarter stepped down to routine outpatient care and community support, and 16 percent had crises that resolved and were now stable.
- In a CHDI evaluation of the Care Coordination, parents were highly favorable--overall, care coordinators had considerable success in securing services for children.

For Outpatient Psychiatric Clinics for Children:

- Outpatient Psychiatric Clinics for Children are licensed and as such, must adhere to regulations as verified through site visits.
- The current program lead for Outpatient Psychiatric Clinics for Children has taken steps to improve the poor quality of the data currently submitted monthly and aggregated quarterly, and make site visits to assess the quality of service (and require corrective actions as needed).
- Although functioning is purported to be assessed by the clinics (using the OHIO scale), there are currently no reliable results for outcome measures.
- A trauma focused evidence-based model is being implemented in six clinics; it is anticipated to extend to 18 clinics within three years; Yale is working with clinicians to obtain fidelity with the model.

For Behavioral Health Evidence-Based Models:

- For adolescents receiving MDFT, 60 percent abstained from substance use 30 days prior to discharge (12 percent had a significant reduction in drug use and 11 percent a significant reduction in alcohol use at discharge).
- For adolescents receiving MDFT, there was a decrease in delinquent behavior with the great majority (86 percent) avoiding re-arrest during MDFT treatment.
- For children and adolescents receiving IICAPS, there have been reductions in the need for institutionalization as demonstrated by a decrease in the number of inpatient admissions, and a decrease in inpatient lengths of stay for those who have had to be admitted.
- Positive problem improvements demonstrate that IICAPS is capable of treating and managing children with serious behavioral health problems in home and in the community.
- The results from recipients of Multi-Systemic Therapy are at the individual client level and have not been compiled or analyzed; definitions of measures are not explained in the reports given to service providers.

For Behavioral Health Federally Funded Grant Programs:
<ul style="list-style-type: none">• The Hartford Youth Project participants had positive treatment outcomes including reductions in alcohol and marijuana use, intoxication, peer drug use, illegal activity, and 5+ school absences; they also had reduced juvenile justice and residential treatment placements.• PARK project staff built a strong partnership with the school system in Bridgeport (viewed as "best practice").• The Adolescent Substance Abuse Treatment Coordination project lacks collaboration/active participation on grant management team by mental health CSSD, family organizations, and evaluator.• Families who participated in Building Blocks and met with the site visit team reported that they are happy with service; however, hiring delays have limited the number of families served.
Source: LPR&IC

Detailed Monitoring and Evaluation Results within Juvenile Services

This section provides information about the results from monitoring and evaluation efforts related to CJTS and Parole Services.

CJTS. *The mission of CJTS is to: prepare boys committed to the Department of Children and Families and placed in a secure facility for successful community re-entry by providing innovative educational, treatment and rehabilitative services. There are six goals for CJTS: 1) create, cultivate and maintain a therapeutic environment at CJTS; 2) develop and implement a comprehensive community re-entry system that builds upon each child's unique strengths and needs; 3) promote family partnerships with CJTS and enhance family participation in their child's growth, development and treatment; 4) promote a commitment to Continuous Quality Improvement through implementation of a comprehensive CQI program; 5) develop, implement and maintain a comprehensive staff development program; and 6) improve the cost effectiveness of the facility by maximizing the utilization of resources.*

There have been improvements to CJTS within its initial five years of operation. Improvements have included changes in punitive policies and more treatment efforts to address substance abuse, clinical and vocational needs. Given the improvements in CJTS service delivery, attention should now turn to improving recidivism rates and other outcome measures.

Parole Services. *The goal of Parole Services is to: help youth successfully integrate back into their communities through supervision.*

Many recent changes have occurred within Parole Services. There are new programs being offered, more frequent and consistent visitation and supervision, and a plan to implement a comprehensive service delivery system. The success of Parole Services overall in meeting the goal of helping youth successfully integrate back into their communities is unknown.

Table IV-8 provides specific results from the 16 monitoring and evaluation efforts reviewed within for CJTS and Parole Services.

Table IV-8. Specific Results for Major Programs Within Juvenile Services
For CJTS:
<ul style="list-style-type: none"> • Two-thirds of the boys were found to have substance abuse issues, and a substance abuse treatment program was implemented at CJTS. • Through changes in policies and programming, such as staff no longer carrying handcuffs and shackles, based on multiple sources, there has been a dramatic reduction in critical incidents, and the use of restraint and seclusion. • Educational programming has expanded to include art therapy, cooking, and vocational/job readiness; there is more clinical treatment, positive leisure time activities, mentors, and more evening and weekend activities. • The recidivism rate for 121 boys discharged from CJTS during Sept. 1, 2005 -April 10, 2006, was 35 percent (22 percent returned to CJTS and 13 percent went into adult criminal system).
For Parole Services:
<ul style="list-style-type: none"> • Inconsistent contact by parole workers with children and families that occurred several years ago has been changed so that all children at home are required to be seen every two weeks by parole. • The array of services has been expanded to include STEP, Targeted Re-entry, Functional Family Therapy and families as allies; however, the effectiveness needs to be evaluated. • A parole manual and job-related training curriculum have been developed; parole staff have received training in motivational interviewing, supervision, and Balanced and Restorative Justice. • A plan has been developed to implement a comprehensive service delivery system (CONCAP).
Source: LPR&IC

Detailed Monitoring and Evaluation Results within Prevention Services

This section provides information about the results from monitoring and evaluation efforts related to the Wilderness School, Positive Youth Development Initiatives, and the Youth Suicide Prevention Program.

Wilderness School. *The goal of the Wilderness School is to: foster positive youth development by providing students with an experience that promotes self-improvement, specifically in such areas as self-esteem, responsibility, and interpersonal skills.*

The Wilderness School appears to benefit nearly all the youth referred to the program. Increases have been reported in self-confidence and self-reliance of the participants, including foster youth who are transitioning to college and other post-secondary experiences.

Positive Youth Development Initiatives. *The goals of the Positive Youth Development Initiative include: strengthening families and good parenting behaviors (Strengthening Families Program) and preventing or reducing substance use (All Stars Program).*

Some of the Positive Youth Development Initiatives appeared effective in strengthening families and good parenting behaviors while others targeted at preventing or reducing substance use appeared less effective. Additionally, some evidence-based models used in the positive youth

development initiatives understated the resources needed to implement the models with fidelity and overstated the generalizability of the model to some of the settings in Connecticut.

Youth Suicide Prevention. *The goal of Youth Suicide Prevention is to: distribute materials and provide training related to prevention of youth suicide.*

Efforts have been made to educate school personnel, DCF social workers, community providers, police, and youth service bureaus in suicide prevention. The goal of distributing material and providing training related to prevention of youth suicide has been met; while difficult to ascertain, it would be beneficial to know what effect, if any, these efforts have had on preventing suicides.

Table IV-9 provides results from the nine monitoring and evaluation efforts reviewed for the Wilderness School, Positive Youth Development Initiatives, and Suicide Prevention.

Table IV-9. Specific Results for Major Programs Within Prevention Services
For Wilderness School:
<ul style="list-style-type: none"> • There was a reported increase in self-confidence and self-reliance for youth who participated in the Wilderness School program. • Nearly all (95 percent) referring agents said the Wilderness School benefited their students. • The Wilderness School is licensed by the Department of Public Health as a camp; it does not currently offer licensure of wilderness programs. • The Department of Public Health found the Wilderness School to be in compliance with 115 of 121 licensing standards; changes were made to correct the minor areas out of compliance.
For Positive Youth Development Initiatives:
<ul style="list-style-type: none"> • After participating in the Strengthening Families Program, parents reported a substantial increase in their good parenting behaviors, families reported having more fun and relaxing together; they viewed the program as helpful and supportive. • There was a doubling of the proportion of youth in the Strengthening Families Program who reported listening to their parents'/caregivers' point of view, and almost all youth (97 percent) perceived that the program had helped them, with over half (57 percent) reporting changes in how things are done together as a family. • All Stars participants showed little change on measures of alcohol use in the pre- and post-tests; however, recent cigarette use was reportedly lower, with no one reporting smoking in the last 30 days on the post-test. • External evaluators found that some program developers of PYDI evidence-based models understated the resources needed to implement the program with fidelity; and different contexts have unique sets of challenges (e.g., issues with translated materials (Spanish not available or incorrect)).
For Youth Suicide Prevention:
<ul style="list-style-type: none"> • Mini-grants for suicide prevention efforts were issued to several schools. • College students, faculty and staff, DCF social workers and community providers were trained in Youth Suicide Prevention. • Youth Suicide Prevention mailings were sent to all schools, police chiefs, Youth Service Bureaus and DCF area offices.
Source: LPR&IC

Detailed Agencywide Results

This section provides information about the results from monitoring and evaluation efforts related to agencywide efforts that occurred within the DCF Office of the Ombudsman, DCF Division of Research and Development, Office of the Child Advocate and agencywide Advising Bodies. Although much is occurring agencywide at DCF, the results reviewed here are specific to monitoring and evaluation efforts that have been conducted to examine the department as a whole and its ability to achieve its mission and agencywide goals.

DCF as a whole. *The mission of DCF is to: protect children, improve child and family well-being and support and preserve families. These efforts are accomplished by respecting and working with individual cultures and communities in Connecticut, and in partnership with others.*

There are limited agencywide results. Based on the modest information available, little can be concluded about the department's overall performance. Table IV-10 shows specific results from the nine agencywide monitoring and evaluation efforts.

Table IV-10. Specific Agencywide Results

- The Division of Research and Development found that staff are concerned about the way exit measures are being evaluated and utilized; family-centered and culturally competent principles to meet the mission are not consistently understood or implemented within area offices or facilities.
- The Child Poverty and Prevention Council January 2007 Progress Report found that children's mental health care had been enhanced with \$1 million for Flex Funding.
- A 2006 child fatality review found no DCF mental health policy, a lack of appropriate residential programs, and inadequate awareness of suicide risks.
- The Office of the Child Advocate found a lack of good assessment of child safety, and failure to accurately determine if abuse is taking place.
 - Cases often lack a complete assessment of family functioning and needs, and parental progress is only assessed by class attendance.
- There was an increase in use of the Office of the Ombudsman from 2005 to 2006 (for inquiries and complaints).

Source: LPR&IC

Summary of Key Findings From Monitoring and Evaluation Efforts

Overall

- External monitoring results are most positive and investigations most negative.
- The agencywide results were more negative than any of the mandated areas.
 - Staff are concerned about the *Juan F.* measures as well as lack of staff adoption of a family-centered, culturally competent approach to service.
 - There is no good assessment of child safety nor mental health policy, while flex funding is seen as an enhancement for children's mental health care.

Within Child Protective Services

- Great progress has been made on the *Juan F.* exit outcome measures.
 - There is consistent compliance with 16 of the 22 measures.
 - More improvement is needed on treatment plans, and needs met.
- Connecticut continues to struggle with federal requirements.
 - The department has failed to comply with AFCARS foster care and adoption data requirements since the initial 2001 assessment.
 - Connecticut met two of six national outcome standards (foster care re-entries, and stability of foster care placements).
 - Connecticut met conformance with four of seven national systemic factors (quality assurance system; training; service array; and foster and adoptive parent licensing, recruitment, and retention).
- Connecticut is one of the few New England states that has shown substantial compliance in its last two Title IV-E Foster Care Eligibility Reviews.
 - The state had improved the content and timeliness of court orders to remove a child from his/her home.
- Hotline services have improved greatly in the past two years in their timeliness of commencement and completion of investigations.
- Connecticut was far behind most other states in having adoptions occur within 24 months of a child's entry into out of home care.
 - DCF made great progress in improving the timeliness of adoptions.
 - The *Juan F.* Court Monitor considers the 9.1 percent adoption disruption rate "unacceptably high."
- Foster homes are decreasing despite recruitment and retention efforts.
- At twice the cost, SAFE Home was found to be no more effective than foster care in reunification and reducing the number of placements.

Within Behavioral Health Services

- Riverview Hospital faces significant challenges that hamper its ability to provide comprehensive, family-centered treatment.
 - The on-site OCA monitor and strategic plan should help advance services received by children at the hospital.
- Caretakers report that Extended Day Treatment has helped improve child functioning; data issues make more objective measures unavailable.
- Following Residential Treatment, one-third of children have improved functioning while one-fifth show deterioration.

- Therapeutic Group Homes are in the process of being opened; to date there is no information on program efficacy; however, the department is in the process of hiring a program evaluator to assess all the therapeutic group homes.
- KidCare appears to have been successful in several areas.
 - Most children in crisis served by the Emergency Mobile Psychiatric Services (91 percent) avoided residential or inpatient care.
 - Care coordinators are considered quite successful in securing needed services for children.
 - A sizeable number of caregivers, however, report dissatisfaction with substance abuse treatment and other services.
- Effectiveness of Outpatient Psychiatric Clinics for Children is unknown.
 - Steps are being taken to improve the quality of data submissions by the clinics.
- Evidence-Based Models in general appear effective.
 - Multi-Dimensional Family Therapy shows promising results in reduction or abstinence in substance use and a decrease in delinquent behavior.
 - Intensive In-Home Child and Adolescent Psychiatric Services shows promise in reducing the need for institutionalization and improving behavioral health problems.
- The federally funded projects have led to positive substance abuse treatment outcomes (Hartford Youth Project), and partnerships with schools in addressing serious behavioral health needs (PARK Project).

Within Juvenile Services

- There have been improvements to CJTS over five years of operation.
 - There were changes in punitive policies; more treatment efforts occurred to address substance abuse, clinical, and vocational needs.
- Many recent changes have occurred within Parole Services.
 - New programs are being offered, and there is more frequent and consistent visitation and supervision.
 - Success of Parole Services is unknown due to lack of data.

Within Prevention Services

- The Wilderness School appears to benefit nearly all referred youth.
 - Increases have been reported in self-confidence and self-reliance of participants, including transitioning foster youth.
- Some of the Positive Youth Development Initiatives appear effective in strengthening families and good parenting behaviors while others targeted at preventing or reducing substance use appeared less effective.
 - Some evidence-based models understated the resources needed to implement and overstated the generalizability of the model.
- Youth Suicide Prevention has taken steps to educate school personnel, DCF social workers, community providers, police, and others.